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Medical Education in Transition

Preschool Hearing Treatment

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the authors

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Since coming to Washington from Rochester, N. Y., in 1948 Dr. Reginald Lourie has set up a full-time teaching program at Children's Hospital, concerned with the application of psychiatric approaches and insights to pediatric practice. While focusing on the training of pediatric residents, the program also includes instruction and supervision of medical students from George Washington and Georgetown Universities in the hospital's well-baby clinic and wards.

Drs. Bordley, at the *left*, and Hardy, *right*, have long been interested in problems of etiology and diagnosis of hearing and related language disorders among children. Both are active clinically and in research and have pioneered in the application of special galvanic audiometry in the diagnostic measurement of hearing in infants and young children. The Department of Laryngology and Otology in the Johns Hopkins School of Medicine has been concerned with hearing and speech problems for thirty years.

A graduate of the School of Applied Social Sciences, Western Reserve University, Miss Thornhill has worked as a child-welfare specialist in the West Virginia State Department of Public Assistance and in the Community Welfare Council of Milwaukee County in Wisconsin. She has also spent a year as a Fulbright scholar in Australia studying services for unmarried mothers and adoption. On her return she accepted a special assignment with the Children's Bureau to round up the facts about unprotected adoptions and to advise on measures for protection.

An expert in the preparation of educational mental health materials, Nina Ridenour began her career as a psychologist in child-guidance clinics in Detroit and Colorado Springs. She has since served as secretary of the New York Committee on Mental Hygiene of the State Charities Aid Association, as executive of the International Committee on Mental Hygiene, and as director of education of the National Association for Mental Health. In 1948 she was one of six United States delegates to the organizing meetings of the World Federation of Mental Health.

frontispiece

FUTURE CORRESPONDENTS, or at least news readers, prepare their school newspaper.

As millions of youngsters such as these troop back to school this fall, educators and lay citizens throughout the land are preparing for the coming White House Conference on Education to be held in Washington, November 28–December 1.

The 2,000 persons expected to attend the conference—70 percent selected by State officials—will focus their attention on six major questions: What should our school accomplish? In what way can we organize our schools more efficiently and economically? What are our school building needs? How can we get enough good teachers—and keep them? How can we finance our schools—build and operate them? How can we obtain a continuing public interest in education?

What medical schools are doing to deepen the physician's understanding of patients as persons.

MEDICAL EDUCATION IN TRANSITION

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MEDICAL EDUCATION is in transition. Dr. George Berry, dean of the Harvard Medical School, has described this transition succinctly as a shift from an emphasis on the "patient as a disease" to the "patient as a human being."[1] Dr. Alan Gregg, vice president of the Rockefeller Foundation, quoting an old French aphorism, has called this a rediscovery of the fact that "there are no diseases; there are only sick people."[2]

That considerable dissatisfaction existed with medical education on the part of medical educators and the consumers of medical care by the end of World War II has been abundantly demonstrated by the subsequent introduction of many changes in the educational process. Some of these changes will be outlined further on in this article. They came about in response to a need for new perspectives in medical education which may be understood best, perhaps, in the light of the historical development of the modern medical school.

As we know it today the medical school is a relatively new institution. At the turn of the century the major part of medical education was provided by numerous proprietary schools scattered throughout the country. Although the trend toward a 4-year curriculum was already underway, the publication of the Flexner report[3] in 1910 accelerated the movement. Consequently, many schools were brought into the fold of universities, a standardizing agency—the Council on Medical Education of the American Medical Association—came into being, and the proprietary schools gradually disappeared. The licensing boards of the various States also sped up this trend.

Along with the building up of the 4-year curriculum rapid advances in the biological and medical sciences were taking place. Accepting their full responsibilities to society and to their university identification, medical schools not only carried out their teaching functions, but also turned themselves into strong research centers. The developments which emerged are now common knowledge. The prolongation of life, the reductions in maternal and infant mortality, the decline of child mortality from infectious and nutritional disorders are but part of the rich harvest of this era.

Because of the relatively uneven development of medical schools, the first half of the 20th century was characterized by an emphasis on raising standards and incorporating new scientific knowledge within the 4-year curriculum. The rapid advances in knowledge presented a real problem, for more content kept being added to the curriculum with each passing year while other subject matter rarely was deleted. Difficult though this was for faculties, it was even more rigorous for the student. Upon one point there seemed to be general agreement: medical students had attained a degree of technical competence never before achieved.

The Criticisms

The major disruptions in medical education and practice associated with World War II and the increasing expectations from medical practitioners on the part of the community stimulated a reevaluation of medical education. This brought forth the following general criticisms:

1. ***Teaching is too compartmentalized.*** The student

is taught by groups of specialists, preclinical or clinical. He has too little opportunity to observe the patient as a whole or to observe faculty members who present an approach to the total patient.

2. ***The student is not brought into contact with patients*** during the first 2 years of the medical school curriculum. The strong motivation with which many students enter upon the study of medicine is therefore unexploited during the first 2 years.

3. ***Content about the impact of social and psychologic forces on the individual has generally not been adequate*** to prepare the student fully for a constructive role in the community on entering practice. When such teaching has been attempted, it has tended to be too didactic to be meaningful to the student; the clinical setting has been used inadequately. An opportunity for the student to develop a background for his own social thinking and insight into his own personality development has been lacking generally.

4. ***Insufficient emphasis has been put on preventive medicine and the maintenance of health.*** The doctor's role in developing a positive health program for our population should complement his concern with the study of disease.

Meeting the Problems

During the past several years, medical schools individually and collectively have been attempting to deal with these problems. The American Medical Association and the Association of American Medical Colleges have jointly sponsored an elaborate survey of medical education, which has now been completed.[4,5] The American Academy of Pediatrics has sponsored a study of pediatric education followed by annual conferences on educational problems.[6] The Association of American Medical Colleges and the American Psychiatric Association have jointly sponsored a conference on psychiatry and medical education.[7] The Association of American Medical Colleges has supported a conference of professors of preventive medicine.[8] Annual teaching institutes concerned with curriculum problems and teaching methods among the various departments of medical schools are currently under way. Conferences on premedical education and on administrative medicine have also been held. The congresses on medical education and licensure sponsored by the American Medical Association and the annual meetings of the American Associaion of Medical Colleges have provided opportunities for the exchange of ideas on educational planning.

Individual medical-school faculties have been vigorous in reorganizing and reintegrating their curricula. Thus while the first half of the 20th century brought about a traditional and relatively static curriculum, the second half promises to be one of increasing flexibility and experimentation. However, the experimentation which is now under way is generally characterized by a healthy maturity and skepticism. In general a real effort has been made to build into these programs opportunities for evaluation of their effectiveness, difficult though any evaluation of an educational process may be.

Lest there be any concern about possible loss in the teaching of scientific medicine it is important to emphasize that the gains which have been made in this area are being carefully protected. There is no desire to have the physician less well equipped scientifically than he has been in recent years. However, some of the new flexibility can be attributed in part to the increasing realization that undergraduate medical education is no longer the terminal education of the physician. Graduates generally proceed with at least 1 year of internship while increasing numbers pursue specialty training for an additional 3 or more years. Thus the undergraduate medical curriculum is only a segment of the training of physicians today. It is folly, therefore, to add information increasingly to the curriculum without reevaluating content with the objective of providing the student with a body of knowledge which his cerebral cortex can realistically deal with and absorb.

New Programs

In order to attempt to prepare the modern physician for his social responsibilities to the community and to deepen his understanding of the patient as a person, a variety of programs are in progress—more than can be described in the space of this article. In one instance these efforts have involved a thoroughgoing reorganization of the curriculum of the medical school. In other instances the attempt has been to introduce new courses within the conventional 4-year curriculum. In general these programs may be summarized as follows:

1. ***A complete reorganization of the medical-school curriculum,*** as exemplified by the program at the School of Medicine of Western Reserve University. In this program curriculum reorganization has resulted in integrated teaching of the conventional subject matter. The faculty has bridged the traditional departmental compartments to present to the student a view of human biology whole. Thus structural, biochemical, and physiological relationships are

taught concomitantly according to an interdepartmental plan by faculty members without regard to their departmental affiliations. As a consequence of this curricular reorganization, considerable revision of the physical plant of the medical school has been necessary, since the student studies in a laboratory of his own rather than in a sequence of departmental laboratories.

The student early in his freshman year begins to work with a family, focusing on the care of a baby. His contact with the family starts in the prenatal period and carries through and after delivery. Guided by a preceptor, his relationship with the family continues over the 4 years of medical school. He learns the role of social workers and other personnel with whom the physician works in planning for the care of patients in the community. Thus an opportunity is provided at the outset for him to develop relationships with patients and to utilize the motivation which presumably brought him to the medical school.

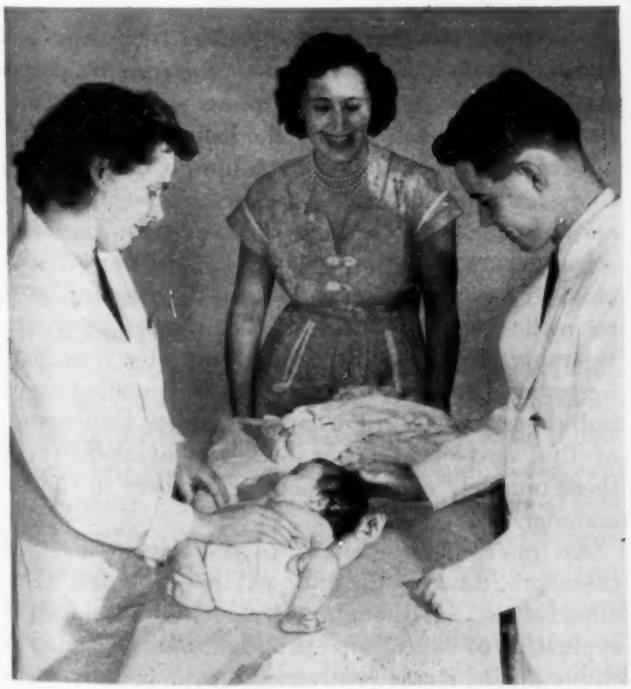
In such a program a strong commitment on the part of the faculty to such a complete reorganization of curriculum and teaching methods is essential for success. Other medical schools have not yet undertaken such complete revision, but the program is being observed with considerable interest and enthusiasm by medical educators today.

*2. **Home care programs.*** Several medical schools in the United States have for a number of years had programs centering around the care of patients in their own homes. Through them students are provided an opportunity to see patients in their social and cultural settings and community relationships and to develop a greater appreciation of the problems associated with their medical care.

The effectiveness of such programs is generally related to the time available and the skill and interest of the teaching faculty. Unfortunately because of the fact that students are often assigned to these programs for short periods of time, usually in the junior and senior years, they have little opportunity to observe continuity of care and to develop the deeper insights into patients' problems which come from repeated contact.

*3. **Outpatient programs designed to provide continuing experiences with patients.*** The Cornell and Colorado Medical Schools have attempted to assign fourth-year students to extended periods in the outpatient departments and to provide them with a general assortment of patients in order that they may have continuing experiences in providing com-

Two phases of Western Reserve University's revised program of medical education. *Left,* a student in the first phase, which concentrates on developing an understanding of the normal, watches a woman pediatrician in a well-baby clinic examine a child as the mother looks on. *Right,* a student of phase 2, which concentrates on a correlated study of the abnormal, visits a patient in the home. In phase 3, a program of comprehensive care of patients in the home will provide the student with continuity of observation, and will be integrated with his laboratory and scientific studies.



prehensive care. This contrasts with the traditional system of rotation through the usual specialty clinics of the medical school. The student has an opportunity to experience the same medical problems which he would ordinarily see in specialty clinics, but at the same time to develop a continuing relationship through which he can deepen his insights into the social, cultural, and personality patterns of the individual and the family. This type of program involves considerable reorganization of outpatient facilities and reorientation of staff. In general, additional staff is also desirable.

Because of the increasing interest in prepayment medical plans, group practice, and labor health plans, such settings are also being utilized for the teaching of comprehensive medical care. They make it possible to place a heavy emphasis on preventive health services, which conventional outpatient facilities often do not provide.

4. Family-study programs. Some medical schools have developed programs providing for long-term study of a sampling of families. Although some of these programs have been established primarily for research into the medical, social, and psychological aspects of family life, students are increasingly being integrated into them. Many programs of this type provide an opportunity for exposure to disciplines as varied as microbiology, immunology, epidemiology, cultural anthropology, social work, psychology, sociology, and the various medical specialties. Some of them focus on providing medical care for a specific member of the family. The care of well babies has been a popular way to give students an opportunity to view family life and its impact on infant and child care. Departments of preventive medicine and pediatrics have been particularly active in supervising such teaching.

5. Programs centering around an understanding of the medical-social problems of the patient. In some medical schools the student is introduced during his first year to the problems which families experience in obtaining and utilizing medical care. Some of these programs, as at the University of Pennsylvania Medical School, have continuity through the 4 years of the medical school; in other instances they are limited to a single year. In these programs the student obtains information from families concerning their medical problems, occupational health problems, and their feelings about the medical care which they are receiving. The students' observations about the family and its degree of integration within the community are discussed in seminars with physicians and social workers. In some schools sociologists, cultural anthropologists, and psychologists have also been drawn into these programs.

6. Earlier introduction of the teaching of psychiatry. In the last decade medical schools generally have introduced psychiatry into all 4 years of their curricula. Although in many instances such teaching in the first 2 years is didactic, it has nevertheless provided students with some knowledge of the behavioral sciences, thus better preparing them to deal with patients clinically. More effective, perhaps, is the utilization of a clinical setting for such teaching, a practice which is gradually becoming more common. In whatever setting, courses in psychiatry also help the student develop deeper insight into his own feelings and attitudes.[8]

7. Courses in human development and human biology. Some schools have attempted to provide students with a better understanding of the total development of man through a dynamic presentation of human growth and development in physical, intellectual, psychologic, and social terms. These courses may be didactic presentations which are largely interdisciplinary and interdepartmental in nature, or they may center around a longitudinal growth study program such as that of the Child Research Council, University of Colorado School of Medicine, in Denver, or in some instances around the observation of the growth and development of an individual baby and family, as in the previously mentioned family-study programs.

8. The introduction of psychology, sociology, and cultural anthropology into the curriculum. Many medical educators have felt for some time that students will learn more about the social, psychological, and cultural background of people if persons with highly specialized backgrounds in these fields are added to the faculties of medical schools. Therefore we are increasingly observing the addition of sociologists, psychologists, and cultural anthropologists to medical-school faculties. Their roles vary considerably from school to school, ranging from participation in research projects to the conducting of individual courses. Perhaps the major significance of this development has been the availability of these uniquely oriented faculty members to the remainder of the faculty.

An interesting sidelight to the development of these programs is the interest in evaluating their effectiveness. Although in years past attempts at evaluation of educational processes were regarded as rather futile, research advances in the fields of soci-

ology and psychology render such undertakings more feasible today. Current experimentation in evaluations seems to have a favorable effect on the educational processes and, hopefully, may provide objective measurement of whether programs are really accomplishing what they have been set up to achieve. Evaluation processes, however, are laborious and expensive and are still highly experimental.

Some Words of Caution

Although the latter half of this century seems destined to be marked by experimentation in medical education, some words of caution are in order. It would be unfortunate if the idea became prevalent that change in educational process can be accomplished by a mechanical reorganization of curriculum or by transplanting courses which have proven effective at other schools. In the last analysis, what and how a student is taught reflects the orientation of his entire faculty. The effective teaching of the social and psychological aspects of patient care is a goal for which the entire faculty must assume some responsibility. Fortunately, a core of medical educators exists who are excited about the possibility of giving students a broader orientation.

No matter how well integrated the faculty, however, the integration of medical knowledge and of social and psychological understanding of patients must ultimately be accomplished by the student individually. Therefore, in addition to a broadened curriculum, the personality and intellectual ability of the student are important factors. This means that problems of student selection emerge as primary in this whole process.

Unfortunately little is known concerning medical-student selection although each school is attempting to study the problem in its own way. Considerable concern exists about the effects of the increasing cost of medical education in discriminating against prospective students from the lower-income portions of our population.[9]

Another note of caution is in order. As has been indicated herein, during the course of his medical-school career the student is increasingly being shown by example the effectiveness of comprehensive care for patients. Consequently, the medical-school program tends to present a somewhat idealized demonstration of community resources and available personnel. This picture is often not entirely in accord with the realities of professional practice for in most communities available facilities are not comparable to the medical-school setting. To obviate feelings of disillusion and despair when the student enters practice, it becomes important that the faculty help him to learn to deal with limited goals. At the same time he should be prepared to aid in the community's planning to provide more adequate services.

Medical-school programs such as have been described here are becoming more and more costly. No longer can the schools depend solely upon individual practioners in the community to carry on the instruction involved. As a consequence they have been steadily enlarging the size of their full-time faculties. If the community desires to have more effective physicians, it will of necessity have to find a means of supporting these enlarged programs. A prerequisite for obtaining the needed faculty members is support for potential faculty members during their extended periods of training. This is increasingly being provided through grants from public agencies, from private foundations, and from fund-raising efforts for medical schools.

Out of the newer developments in medical education more effective health services to our Nation should become available without sacrifice of the rich tradition of our medical schools. In the words of Dean Berry, "Scientific medicine must become comprehensive medicine, yet not become thereby any less scientific." [1]

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[1] Berry, G. P.: Medical education in transition. Journal of Medical Education. 28:17, 1953.

[2] Gregg, A.: Conference of Professors of Preventive Medicine. Colorado Springs, 1952. Association of American Medical Colleges, 185 North Wabash Ave., Chicago, Ill.

[3] Flexner, Abraham: Medical education in the United States and Canada; a report to the Carnegie Foundation for the Advancement of Teaching. Boston: D. B. Updike, the Merrymount Press. 1910. 346 pp.

[4] Severinghaus, A. E., Carman, R. J., Cadburn, W. E.: Preparation for medical education in the liberal arts college. New York: McGraw-Hill. 1953.

[5] Deitrick, J. E., Berson, R. C.: Medical schools in the United States at mid-century. New York: McGraw-Hill. 1953.

[6] Child health services and pediatric education. Report of the Committee for the Study of Child Health Services, The American Academy of Pediatrics. New York: The Commonwealth Fund. 1949.

[7] Psychiatry and medical education. American Psychiatric Association. Washington. 1952.

[8] Fey, W. F.: Two psychiatries: problems in teaching them. Journal of Medical Education. 30:97, February 1955.

[9] Gardner, L. I.: Economic segregation in American medicine. Journal of Medical Education. 30:373, July 1955.

The common sense of doctors, nurses, and other health workers can make a difference in . . . .

DELINQUENCY PREVENTION — A HEALTH WORKER'S JOB, TOO

REGINALD S. LOURIE, M. D., *Director, Department of Psychiatry, Children's Hospital, Washington, D. C.*

IT IS GENERALLY AGREED that what this country needs is a good common-sense solution to the problem of juvenile delinquency. However, some common sense is being applied to the problem every day in almost every community, while the incidence of juvenile delinquency keeps on growing. What seems to be lacking is the concerted use of all the kinds of common sense available. If the common sense of doctors, nurses, and others in the health field were added to that supplied by the legal, law-enforcement, welfare, sociological, educational, and law-making facets of the community perhaps the efforts would have a better chance of working. The health field has a body of information available, particularly about the structure of the brain and personality and about the interaction between the body, mind, and environment, that can bring all common-sense approaches to delinquency closer to realities.

Our experience shows that in the first 5 or 6 years of life the basic elements of personality are established. We also are aware of many of the elements that can go wrong and distort the resultant personality. This information must be made an integral part of the professional equipment of all people trained in health work if they are, in their distinctive ways, to apply it in their everyday dealings with children who act out personality distortions. Trying to deal with delinquency without this knowledge and skill is like bringing a car to a garage because it does not run right and having the repair people clean the windshield, straighten the fender, fix the tires, but never lift up the hood because they have never been trained to know what is under it and what they can do with this to effect minor or emergency repairs. Thus, we need to bring not only into schools of medicine and education but also into schools of nursing and health education and into the training of the technical aspect of health services, teaching about personality development, the principles of interviewing and those involved in therapeutic approaches to people's problems, as well as knowledge of community resources and how to reach them.

True, some professional persons are fearful of bringing this content into teaching, particularly when they interpret it as creating a tremendous army of therapists rather than as spreading information. They forget that most people in trouble do not turn to the specialized mental-health services but rather to the rank and file of health workers. Have these unspecialized workers any right to deal with personal problems? This is an academic question not only because of the dearth of specialized services in most areas but also because health workers are dealing with such problems all the time. They are forced into this position by the people themselves and by courts, schools, institutions, and social agencies, which frequently ask them to participate in the care and disposition of children already in trouble. Therefore teaching health personnel something about what goes into normal and abnormal mental functioning would give a better guarantee as to the kind

of help they would provide. What is needed is an army composed: first of all of casefinders; second, of persons qualified to deal with a large number of problems that normally arise in regard to children; third, of persons who can provide emergency assistance or consultation for serious difficulties; and fourth, of knowledgeable persons who would be in a position to apply preventive techniques.

Casefinding

First comes casefinding. Health workers of all kinds are in a position to see problems that might otherwise be overlooked. When a person lets down part of his defensive armor with those who take care of his physical difficulties—taking off clothes may be the first step in this—it becomes easier and even natural for him to talk about other difficulties. This is when it is important to recognize what he reveals. If the health worker knows how emotional difficulties are rooted in unsolved phases of personality development and how physical handicaps and brain damage influence the ability to solve fundamental problems in relationship or to obtain satisfaction from living he will be able to explore these areas of functioning in the course of his other services. Otherwise they might never be explored until the patient gets into trouble in the community and forces the community to do something about it.

Frequently a simple question about adjustment in school, or to siblings, or to parents, or to social life—directed to the school, or to the parents or the child, or both—opens doors that people did not realize could be opened or elicits such responses as "I didn't know you cared about this." On the other hand, the response may be: "It isn't any of your business" or "There isn't any trouble at all" when trouble very evidently exists. At such a point a well-prepared health worker need not feel luckless or frustrated. With interviewing skills at his command, he can keep the subject open instead of having the door closed in his face.

The health worker needs to know something of personality structure and interpersonal communication to be helpful not just to the person or the family asking for help and able to use it, but also to those who do not see the need for help or who cannot accept it after they ask for it. He needs to know enough to recognize when people—adults or children—are unable to relate to others, are unsure or frightened, disorganized, and asocial and how these patterns affect those about them as well as themselves. He needs to know what is symptomatic about the predominant use of denial, passing the blame onto others, withdrawing and avoiding, or guilt-burdened overprotection. He needs to know how to avoid getting involved personally with the people he is trying to help or feeling personally hurt or rebuffed by rejection of proffered help. He needs to know how his patients handle their emotional problems in the same way he knows about their handling of physical problems.

In whatever setting the health services are being offered, whether it is in the plant, the office, the school, the home, health workers need to keep their eyes and ears open—and might have to open their mouths—in order to stop the kind of difficulties that could lead to disturbed behavior. We do not have enough knowledge at this point to be able to predict definitely when emotional disturbance will end in acting out or in overt delinquent behavior, so that we need to think of dealing with any and all forms of deviant behavior and adjustment if we are to make advances in spotting the potential or early delinquent.

Provision of Services

The next two points must be considered together—the provision of services to those we should be able to help without any outside assistance, and of emergency services to those who need more continuous or specialized help.

To understand better what the role of the health worker can be in such instances we should take a look at what the sources of problems in children are. A good working etiological classification, although by no means complete, finds them stemming from five areas:

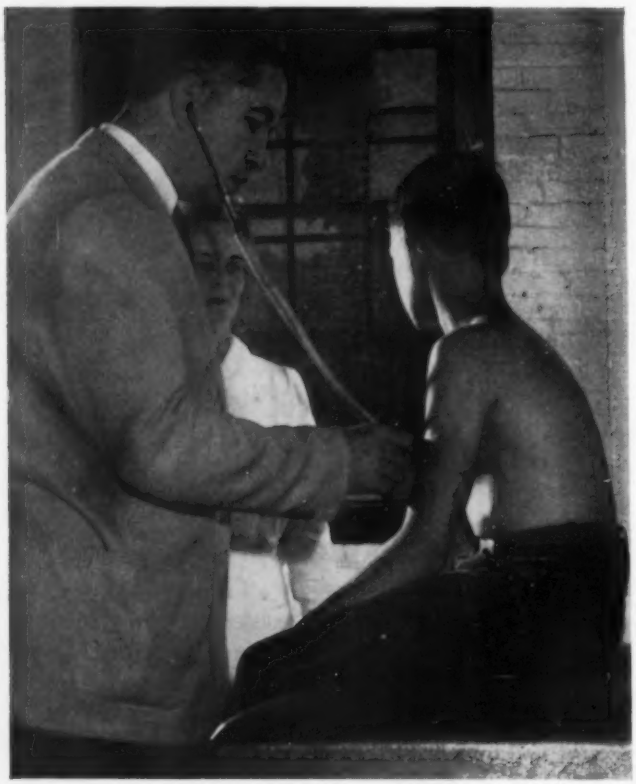
1. Faulty training.
2. Surface conflicts, as with parents and siblings and in the social, learning, and sexual aspects of functioning.
3. Deep conflicts (neuroses).
4. Physical difficulties, including handicaps, brain damage, metabolic disturbances and poorly handled convalescence.
5. Mental difficulties, including psychoses and mental deficiency.

The first two groups account for 80 percent of all the problems children present. This means that the vast majority of children's problems do not require the mental hygiene team's approach nor specialized psychiatric care. In four-fifths of all the emotional disturbances that health workers encounter the roots are shallow and are easily dug out. To get at them, however, it is necessary to spot the etiology of the

problem, since the symptoms are relatively nonspecific and are different with different individuals. For this the health worker can use as a frame of reference the current body of information on normal personality development and on where and how the snags in it develop. Then, after talking with and observing the patient, common-sense answers as to the corrective procedures called for will usually be forthcoming. This approach is available to the general practitioner, the pediatrician, the clinic, the hospital and school nurse, as well as to many others. In other words, if we lift the hood of the car, we find that there are many things that health workers are competent to handle short of taking apart the more complicated parts such as the carburetor or the engine itself.

Sometimes, however, the symptoms themselves do not reveal whether the disturbance is superficial or deep-seated. Even then the health worker should try his corrective surface approaches in order to find out whether the specialist's deeper probing into the engine is necessary. Contrary to some opinion, this topical application of knowledge will not harm most persons whose difficulties are too deeply rooted to be affected by it. Enlightened health workers have a better chance of being right than the neighbors, than Grandma, than the mother-in-law, than the storekeeper, who usually have already offered some kind of advice by the time the problem comes to the health worker's attention.

Health workers are often in a position to spot incipient personality problems, for a young person's defensive armour often breaks down with those who take care of him physically.



When faced with acute flareups in their clinical contact with families health workers confront many practical difficulties. The easiest out is to make a referral, but this is not always possible. There may be no mental-hygiene clinic in the community, or if there is, it is likely to have a waiting list 6 months long and a heavy load of "emergency" cases, making even an "intake interview" an impossibility in less than a week.

In acute flareups, however, a family needs help immediately in handling the child who is running away, or setting fires, or has been caught in an asocial activity that has aroused the neighborhood, the school, or the parents into a call for action. The anxiety engendered at such times is acute, and it is often this anxiety, with its resulting changes in homeostatic balance, that makes it possible for people to seek or accept help.

We learned some lessons about this in the combat areas in the last two wars. When a soldier became acutely anxious or distressed on the front lines in Korea, if possible he was interviewed right behind the lines, allowed to sound off about such things as his fears, his worries and all the injustices, past and present, to which he had been exposed. Then he was reassured, rested and reassigned and an awareness created in his environment about some of his needs and about the things he could properly avoid. He usually was then able to get to the front lines again as a participating soldier. However, if he was sent back from the front to the field hospital, to the base hospital and eventually to the general hospital, the chance of his functioning again as a useful soldier became slimmer and slimmer. In other words, in emotional disturbances, it is when the pain is acute that we can often be of greatest assistance, particularly in keeping a family or an individual from withdrawing further, becoming more hostile and vengeful, accepting new ways of functioning with others or reacting with more strife or disorganization.

What can we validly do at such points? There is a widespread opinion that the only valid approaches are those of the psychiatrist and of the psychiatric clinic and that their techniques are sacrosanct. However, as we look over the evolution of our philosophies of treatment, we see that we have gone

through a number of phases, starting with doing something *about* children in trouble, going on to doing something *for* them and finally to doing something directly *with* them. Perhaps there are still plenty of things that can be done *about* and *for* a family in acute trouble. Environmental deficiencies can be modified, deprivation corrected, trust established or reestablished, resentments aired, physical handicaps dealt with. Community resources can be mobilized.

Moreover, there are levels of working with patients that can be therapeutic without becoming profound involvements. Since the basic element in most forms of therapy is the relationship between the patient and the therapist, the resultant corrective emotional experience can be an integral part of the emergency services that health workers are in a position to offer. It can be like dealing with a very painful abscess by making an adequate incision that allows the pus to erupt and drain or, if there has been a spontaneous rupture, making sure that it does not wall over again and remain a constant irritant. At the same time we can look for the kind of long-term assistance that can provide more direct working with family members. Unlike the surgical emergency, the personal crisis may go on for days and weeks but mistakes in dealing with it are not nearly so costly as in surgery for they are rarely fatal.

We will always find persons who refuse help even for abscesses. This calls for reevaluation of the health worker's policy of waiting for patients to seek their services—especially when the pathology involves the community. In social work a new kind of aggressive, "foot-in-the-door" type of casework is evolving. Even if a whole family cannot be reached, finding one individual in it who can be worked with may be worthwhile. It may be necessary to deal with the child even if the parents will not participate. Children can be helped to achieve an amazing degree of tolerance about the people and conditions around them.

That such emergency measures can be effective and can be used on a large scale has been demonstrated by Rosenfeld and Caplan in Israel.[1]

Practical Difficulties

Health workers need to reassess their skills and knowledge to see how the personnel available can fit into the provision of such services. The greatest hazard to providing this kind of on-the-spot help are the health workers themselves. They may be too busy or afraid to use psychiatric techniques, or they may be people who cannot listen, who have to tell people what to do, or who themselves find it hard to relate to others. One of the greatest drawbacks is represented by those workers who do not believe in mental mechanisms or merely give lip service to body-mind concepts.

Health workers with interviewing skills and knowledge of personality development can lessen parents' worry about normal paradoxes in child behavior, alert them to incipient trouble, and help them accept referral when necessary.

A perennial question among the doubters is where to find the time to fit such procedures into full daily schedules. It is true that a busy doctor or nurse cannot take a half hour or an hour to ask questions and think through the evidence at hand, especially when the waiting room is becoming a bedlam and time for lunch or outside calls is running short. True, too, this cannot be done in a routine 15- or 20-minute office or clinic visit. However, numerous ways have been worked out for having a more concentrated block of time available, such as setting aside an hour a week for consideration of an emotional problem or another health problem that requires more than routine time. This practice can actually be a time-saver. Think of the number of 15-minute sessions devoted over a year to an effort to break down a stubborn habit problem about which a lot could be learned in a single long session.

The idea that personality distortion might be prevented goes back in this country to the pioneers in American psychiatry. With each step forward in our knowledge has come the hope that a new preventive method has been found. With each failure in application of our knowledge has come a wave of pessimism about the possible effectiveness of preventive efforts. We are currently in a phase of optimism because our present insights into mental functioning

are proving more and more valid for spotting the kinds of parent-child interaction that are known to lead to distortions in personality development.

This interaction starts with the attitude of the mother to her unborn baby. There are all kinds of people in the world and most of them have children. There are psychopathic, psychotic, immature, and unrealistic parents as well as those with neurotic attitudes about such things as feeding, affection, cleanliness, and constipation. Thus, what has come to be somewhat euphemistically called anticipatory guidance needs to be concerned not only with the forms and practices that have to do with the rearing of children but also with the feelings involved.

Health personnel must be trained to listen not only to the words but also to the music of what goes on in the families that they deal with. It is not enough for them to provide intellectual approaches to the expectant crises that stages of personality development bring. For example, we have learned a great deal about what can go wrong with the feeding processes. As a result, in many areas well-baby clinics are reporting few of the formerly prevalent feeding problems. However, they report many more sleeping problems. We have also found that changing the forms of toilet training from the early rigid practices to more relaxed, more logically timed approaches does not change the incidence of anal character traits. The more subtle identifications with parental personality attitudes and responses cannot be influenced simply by changing outward forms. The normal fears, such as separation and bodily hurt, will still be difficult for a child to deal with if his responses to them cause anxiety in a parent. Thus, health workers need to know, whenever possible, something about the parents to whom they are giving advice, so that they will tend less to deal with them as stereotypes and will take into account their individual constitutional makeup, along with organic elements and the environment.

Education and Research

To achieve this we need to turn to our professional schools and think in terms of teaching procedures and supervision calculated to provide awareness of self and others, such as has been demonstrated as feasible in schools of social work and is creeping into the medical schools and schools of public-health nursing. We might also reexamine the values of our educational approaches for corrective as well as preventive efforts.

An element that is often overlooked in preventive efforts is the importance of continuity. This means followup by health personnel not only from the prenatal through the preschool years but also through the grammar- and high-school years. The sharing of information by health personnel with welfare, school, and law-enforcement agencies is also an important factor in allowing these agencies to proceed in an enlightened manner with children in trouble.

While we have a long way to go to spread the information we now know about personality development and the ways in which it becomes distorted, we are also a long way from knowing all we need to know—especially about the developing ego and how it deals with the aggressive drives, the nuclear problem in understanding and dealing with juvenile delinquency. Research, then, must take a top place in our preventive efforts.

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[1] Rosenfeld, Jona Michael, and Caplan, Gerald: Techniques of staff consultation in an immigrant children's organization in Israel. American Journal of Orthopsychiatry, 24: 42–58, January 1954.

Any person who tries to help another should establish *rapport*. Through training, experience and self-criticism, the psychologist or social worker learns to reduce fear and shame. He must really like people and believe in them. In his heart of hearts, he knows that successful persons achieve their status through a combination of events for which they can claim only partial credit. He knows that countless families live close to the margin, close to humiliating forms of poverty, neglect and social ostracism. He knows that skin color, nationality, inheritance, poor health and poor education may leave their mark upon a child long before there is a chance to make good as a *person*.

—George D. Stoddard, New York University, at the 1954 Forum of the National Conference of Social Work.

Veteran hearing-aid users under 6 prove the great social and emotional gains that come from . . .

TREATING YOUNG CHILDREN FOR HEARING IMPAIRMENT

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THE CHILD WITH IMPAIRED HEARING presents a special challenge in diagnosis and treatment, and, when disability is permanent, in development and training. Because of the close relationship between impaired hearing and behavior, the earliest possible diagnosis is indicated. Hearing disability inevitably promotes deviant behavior, with varying consequences to the individual's welfare.

The etiologic pattern is diffuse. The great majority of infants and young children with hearing handicaps suffer from injuries to the auditory nerve, or central damage, rather than from the middle-ear conditions resulting from upper-respiratory infection, common in school-age children. In the past 5 years approximately 2,000 children under 6 with hearing difficulty have been examined in the Hearing and Speech Center of the Johns Hopkins Hospital. In a small number of them the impairment is clearly assignable to familial traits; in a large number it belongs in the category of undeterminable etiology. Some of the latter have had no contributory medical histories, while others have had such agglomerate histories that precise determination of cause is impossible. The remainder, about 75 percent of all, can be subsumed etiologically as:

1. Ultra-virus infection of the mother in the first trimester of pregnancy—the causal factor in a high percentage of hearing impairment among young children.
2. Prolonged or severe anoxia at birth.
3. Birth injuries and prolonged labor with instrumentation.
4. Erythroblastosis, an anemia connected with Rh incompatibility of mother and fetus. This is a prevalent factor in auditory impairment among athetoid children.
5. Severe viral infections in the first 6 to 8 months after birth, damaging to the hearing structures.
6. Meningitis, particularly influenzal meningitis of the very young.

Presented at the meeting of the Medical and Chirurgical Faculty of Maryland, April 21, 1955.

Types of Impairment

The incidence of hearing impairment or relatable language dysfunction among preschool children is rapidly rising. This may be attributable to the fact that modern obstetrics and pediatrics are saving more and more defective children who formerly might not have survived. All the classical types of hearing impairment have been found among this age group but the proportion of pure conductive lesions is small.

Nerve-type or perceptive impairments are caused by atrophy or underdevelopment of the cochlear nerve, or organ-of-Corti cells, in the inner ear, or to lesions somewhere along the central auditory pathways. High tones are commonly more affected than low tones. However, when the hearing loss is severe, whatever the cause, both high and low tones are involved. The effect is not only of lessened intensity but also of acoustic distortion so that understanding as well as hearing is impaired.

In general, no adequately demonstrated treatment for perceptive impairment exists. However, total

nerve-type deafness is extremely rare in this age of early diagnosis and advanced chemotherapy. The fact that a child does not appear to respond to the ordinary limits of sound does not mean total impairment. It is a rare child, indeed, who does not have some residual hearing. The determination of how much is a matter for clinical testing.

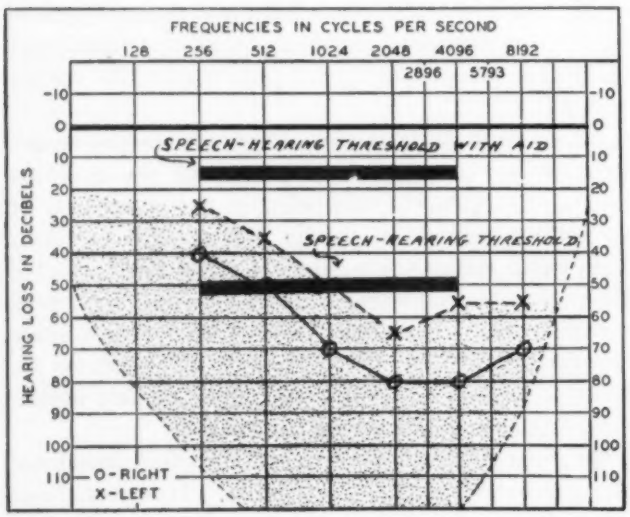
Conductive impairment results from interference with the mechanics of audition in the external canal or in the middle ear. The effect is the dampening of the transmission system, thus diminishing the intensity of sound. While this never results in total deafness, it may cause great difficulty in communication. Children with conductive impairment are apt to live in a world of "muddy" sound wherein clear distinctions are difficult to make, thus hampering their ability to pay attention. In the very young child this penalty is particularly severe and commonly causes considerable retardation in both language development and social maturity. In many children with conductive impairment, hearing, and therefore behavior, fluctuates greatly, to the confusion of their families.

Conductive-type hearing impairment in a very young child is usually amenable to treatment, when diagnosis and followup action are promptly undertaken. A conductive-type impairment involving midline adenoid tissue and obstruction of the Eustachian tubes often complicates a basic nerve-type impairment. This can be relieved by medical and surgical therapy, to achieve a permanent baseline of hearing.

A psychogenic hearing impairment also exists which presents no symptoms of otic pathology but affects normal functioning. By no means rare in children, this usually presents a difficult diagnostic problem.

Another problem evidently rapidly increasing in incidence is only apparently one of hearing. A child fails to respond to sound although he has a normal hearing end-organ. The core of the problem is at a higher level, in the cerebrum, and involves not the reception but the perception of sound. Sound penetrates to the brain, but lesions there or developmental lacks prevent a normal association of it with meanings and therefore interfere seriously with the development of appropriate responses and of the structure of the verbal symbolism called language.

Figure 1.



Hearing Evaluation

Evaluation of a small child's hearing acuity and potential is not a simple process. It requires a careful case history with special attention to prenatal and natal events which could be causal factors, the time parents suspected a hearing loss, possible contributory data in postnatal history, and the degree of normality in the child's physical and social development as well as a careful study of his reactions to sound, including direct observation of the child and inquiry of the parents. It also involves careful observation of the child's play activity, his adaptation to new situations, his motor development, attention span, and social maturity.

Otherwise normal children with impaired hearing soon become highly visually-oriented; by the age of 24 to 30 months they will have developed an extensive gesture language. Those with a fair amount of residual hearing will be using their voices quite consistently in babble and will have made definite attempts to communicate verbally. Very deaf children will not continue to babble freely, for they cannot monitor their own vocal attempts well enough. Those with central disorders, wherein the trouble lies in the cerebrum rather than in the end-organ, will commonly ignore sound or respond only sporadically.

A thorough diagnostic work-up involves a complete otorhinologic examination, including careful inspection with a nasopharyngoscope. Important, too, is careful pure-tone audiometry. A difficult procedure with most young children with impaired hearing, this usually requires the services and facilities of a special clinical center. However, general physician can find out a lot about a child's hearing provided that the sounds he uses for testing are of known values of intensity and pitch.

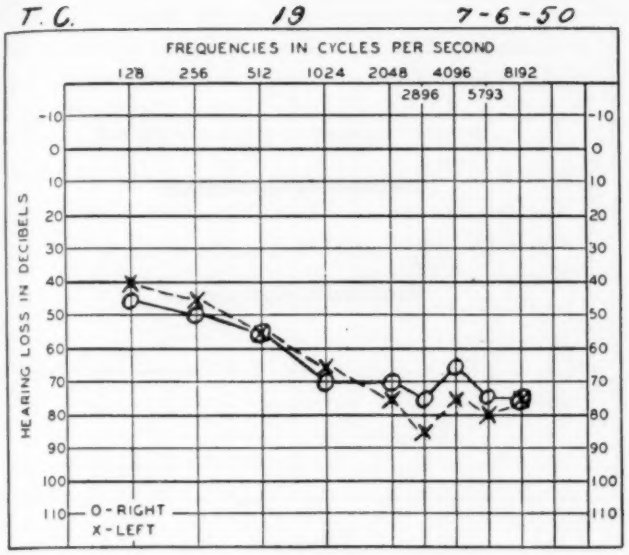


Figure 2.

The early detection of hearing impairment in young children depends largely on the astuteness of the pediatrician and the general practitioner in interpreting the developmental history and in observing the degree of language development.

A child talks because he hears and as he hears. Gradually, with much imitation and reiteration, he begins to relate sounds to meanings and to develop language comprehension; only then does he start to talk. If the child's hearing is severely impaired, ordinary sound is meaningless to him; very loud sound will capture his attention but will not continue to do so until and unless it becomes a daily, hourly experience. If he has a moderate-to-severe impairment, with fairly good residual hearing for low-pitched sounds, he will respond to a variety of sounds if paying attention to them is worth while.

Some children, with severe acoustic distortion—good acuity for low pitches but rapid deterioration as pitch increases—learn very soon to ignore sound. Hearing something of everything but not enough of anything, they have little opportunity to learn to discriminate between father's voice and mother's voice, or the telephone bell and the tinkle of the Good Humor man. In a world wherein most sound is very much alike, they will stop making the unrewarding effort toward an impossible differentiation. Consequently, many are mistaken as mental defectives.

A similar sequence may be implicit in the behavior of the brain-damaged or cerebrally maldeveloped child. In him sound penetrates the analytical structure of the end-organ but is not translated readily into meaning at the cerebral associative levels of differentiation and recall. Thus the development of normal language symbolism is blocked. These children need special training which is very different from the kind needed by the deaf child.

In plain terms, children with severe hearing impairment do not develop naturally as do their peers with normal hearing. Lacking a fundamental component of the natural means to communicate, they find learning a slow and complicated process. Moreover, many of those who come to clinical attention present a combination of defects—auditory, intellectual, and psychological. The diagnostic problem frequently resolves itself into a determination of whether hearing impairment plays any part in the deviant development.

Between the ages of 2 and 6 years children are highly absorptive and responsive and at their peak as natural language-learning mechanisms. Therefore, medical or surgical measures to correct hearing loss should be carried out as early as possible. Children with permanently impaired hearing must have a careful evaluation of its degree and the relation of this to general development and behavior, so that plans can be made for habilitation or rehabilitation.

Few children are totally deaf; most can gain some material benefit from the use of a wearable hearing aid. Once the picture of the child's hearing loss and potential is obtained, effort should be made to put his residual hearing to use as an adjunct in learning language. For children with profound hearing defect, vision must be the basic stimulus, with audition an adjunct. For those with a relatively large amount of residual hearing (down to about 65 decibels below normal), audition can be basic, as it is normally, with vision adjunctive in language learning. Many children whose hearing impairment is moderate or severe can be brought to normal functioning with training and the use of a hearing aid.

A Communicative Dysfunction

Deafness is a dysfunction not only of the ears but of the listening mind. Many children with quite good potential levels of auditory acuity become functionally deaf because they have never had the opportunity to learn to hear. A recent diagnostic analysis of 572 preschool-age children suspected of hearing impairment because they did not develop normal language and speech, revealed that 116 had normal auditory end-organs. Their developmental lacks were caused by a variety of factors, from mental deficiency to behavioral pressures. In this study

speech-hearing potentials were generalized from pure-tone audiograms obtained by a special measuring technique, galvanic skin-resistance audiometry. In this procedure a very young child responds to sound with an involuntary reflex.

Over 2,000 preschool-age children with hearing difficulty have been tested by skin-resistance audiometry in the past 5 years. Only 27 percent were found to be profoundly deaf. Apparently only about 30 percent of educable children with hearing impairment are educatively deaf, that is, require special residential or day-school training.

All children with handicapping hearing impairment require special help at both preschool and school ages; how much and what kind depends on the child's particular needs and capacities. Those with mild or moderate impairment are well within reach of a wearable hearing aid and, other things being equal, can be expected to function within normal hearing range. Those with severe impairment require a great deal of careful analysis and special help. Whether eventually they will emerge as "hard-of-hearing" or as "deaf" children depends largely on the way they are handled and how society helps them meet their problems.

The 2-year-old with a severe hearing impairment does not belong in school; he is not yet ready to learn in any formal regimen of teaching. Once the clinical picture is clear, his parents must be taught every possible insight into his needs and ways to meet them, how to help him discriminate between sounds and to learn language, usually with the constant use of a wearable hearing aid, and eventually to develop understandable speech. This as well as the determination of hearing loss and potential is an important aspect of clinical audiology.

Some Case Histories

The following cases illustrate the importance of early case finding.

Figure 1 shows the audiogram of a 6-year-old whose hearing impairment was caused by toxemia in her mother during pregnancy. When she was first seen at the clinic at the age of 2 her hearing for tones below 1,000 cycles was much less than this audiogram shows. After retest was done by galvanic audiometry she was fitted with a wearable hearing aid at the age of 26 months. She developed language and speech well. The dark lines are actual threshold measurements of her speech-hearing ability. With her hearing aid, she functions well within normal range. Now 7 years old, she is in a regular second

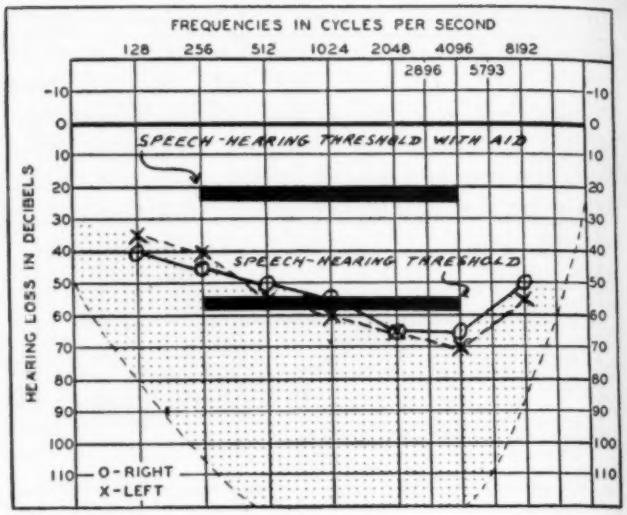


Figure 3.

grade at school and is leading a normal life.

In contrast is *figure 2*, the chart of a young woman graduate of a conservative State school for the deaf. She was 19 when she was first seen at the clinic. Her speech is extremely limited. Communicatively and psychologically, she is a deaf person, although her unaided speech-hearing threshold is only a few decibels below the first child's. She has grown up in a world of silence. With a hearing aid she too could perceive simple speech within normal range. She does not know the hearing world, however, and does not want to know it. The mind becomes deaf when the ears are not helped to convey sound.

Figure 3, the chart of a 9-year-old boy with nerve-type hearing impairment, illustrates the same point. Audiometric testing puts him at the level where ordinary conversation would not penetrate without a hearing aid. He has had special help at home in language and speech training since he was 3 years old. He has always attended a regular school, where he is doing superior work. His life is entirely normal; he is fully oriented to the world of sound; he is not deaf in any sense of the word, but he would be lost without his hearing aid.

Figure 4 shows the audiogram of a child with severe acoustic distortion. This boy's hearing impairment was caused by chickenpox at the age of 2 months. He is normal in all respects except in hearing ability and language development. Now 5, he has worn a hearing aid since he was 3 years old. Slowly he is making progress in language differentiation. His mother works with him daily. He has also had considerable help from a speech-hearing

therapist attached to the school system in which he has been attending a class for normal preschool children. He needs daily school work in language, audition, and speech, but this is not available.

Figure 5 shows the audiogram of a child who is educatively deaf. His impairment is of undeterminable origin. The heavy line represents mathematically his threshold potential for speech-hearing derived from the pure-tone audiogram. Now 5, he has been wearing a hearing aid for 2 years; sound is meaningful to him, but his impairment is so great that sound can never be the foundation for language learning. What he hears is a most useful adjunct to what he sees. He is in a special class for preschool deaf children and demonstrates a rapidly developing language-mind. If this development continues, he should be able to communicate quite understandably by the time he is at a high-school level.

Figure 6 shows an interesting progression of development from awareness of sound to the emergence of language meanings. At 3 years and 2 months the boy whose hearing is charted here had a few unconnected words and some language understanding. He was aware of voice and toy-sounds at the level of 30 to 35 decibels below normal. When the examining otologist found clear evidence of a conductive element in his hearing problem, a tonsillectomy and adenoidectomy were done. The second audiogram, made 5 months later, shows definitely better thresholds for pure tones with quite normal levels in the low-pitch ranges. Awareness had been improved by 10 decibels. The boy was obviously more alert and responsive to sound of all kinds. A third audiogram, made about 18 months after the first, shows that the pure-tone acuity had remained stable. By this time it was possible to test the child's hearing for speech. The resulting 30-decibel level was not considered threshold as few 4-year-olds with distorted hearing can listen to a precise speech-hearing threshold. Auditory meanings were well on the way, however. Now, at the age of 6 years, this child is getting along well in a regular first grade. He wears a very light-gain hearing aid, with a specially adapted earmold.

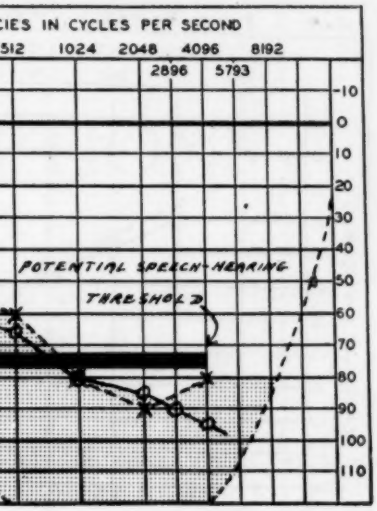


Figure 5.

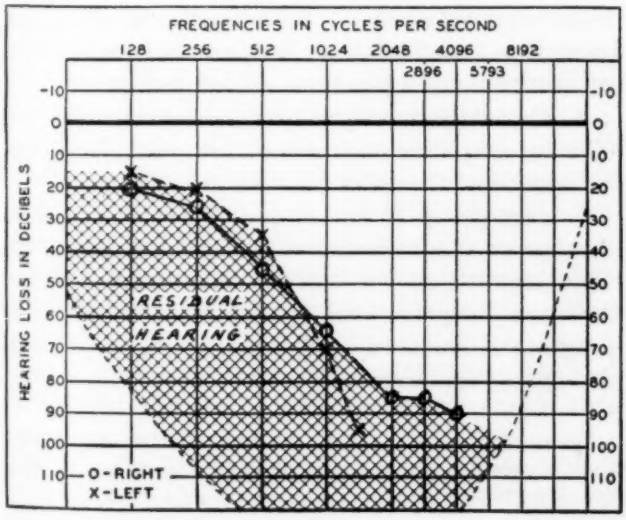


Figure 4.

Some Basic Concepts

A few generalizations can be made from our experience of the past several years in dealing with a large group of preschool children with hearing handicaps. These encompass 10 basic concepts:[1]

1. Hearing rehabilitation is a many-sided cooperative endeavor involving the pediatrician, the otologist, the clinical audiologist, the psychologist, the teacher, and, above all, the parent, working as a team.

2. Communication ability in children with hearing impairment involves acoustic, linguistic, visual, behaviorial, developmental sensory-motor, and social elements. Hearing, speech, and language cannot be isolated from one another or divorced from the overall developmental processes.

3. Treatment and training should be based on a full diagnostic appraisal including an early measurement of the amount of residual hearing, and, when possible, the child's ability to use it.

4. Treatment and training should be started as early as possible in the child's life, preferably be-

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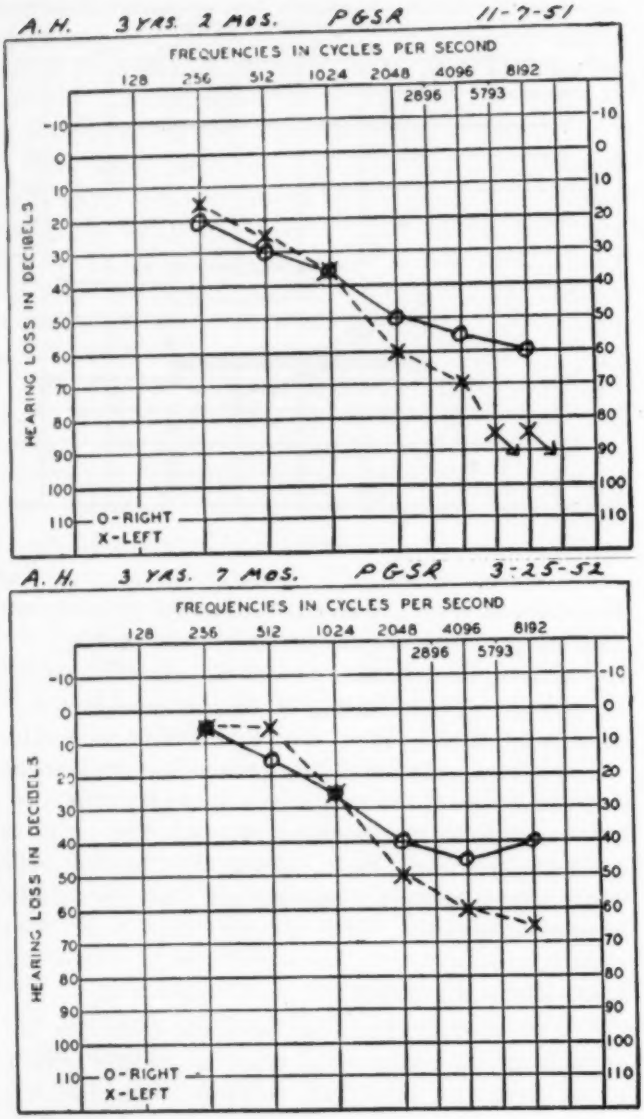

Figure 6.

tween the ages of 18 to 30 months. So far as tools of communication are concerned, the child's career begins in infancy.

5. With appropriate handling, many children having a profound impairment can learn to understand speech and to talk.

6. The majority of children with impaired hearing have a great deal of residual hearing and can make good use of amplified sound, providing this is started at an early age when sound can become an integral part of the developing mind. Even the child with a profound loss can benefit from amplification to some degree.

7. Wearable hearing aids provide the means for putting the child in contact with sound through all his waking hours. Children seem to make the best adjustment to them between 2 and 3 years of age, but the time for providing the aid must be set for each child according to his readiness and needs.

8. Some special handling is always necessary at home and at school for children with handicapping hearing impairment. Whether it should involve special work in a regular nursery school or elementary school or in a special day or residential institution is a task for careful audiologic-educative determination.

9. Most children develop best in a situation that is the closest approach to a normal setting, while meeting their special needs.

10. Parental understanding and parent guidance are the keys to working with children having severe hearing impairment. Progress with the child is usually made in direct proportion to the parents' understanding and acceptance of the problem they face. They need to understand how communication develops, and how they can and must stimulate it in the minute-by-minute experiences of their child. They must be shown how to communicate clearly and simply at short distance, using the same vocabulary over and over in a wide variety of situations, until meaningful associations are grasped and the child begins to relate and store them, and eventually to reproduce them in his own speech. They must learn how to anticipate communicative requirements and to expand the child's vocabulary.

Two Principles

This framework rests on two convictions which have special implications for medicine and education:

1. Although each child is a unique individual, with his own special needs in communicative development, generalized methods can be made to work as the professional team learns to work together.

2. The utilization of modern electronics makes possible an emphasis on hearing, not deafness, in the prospectus of the child's future.

A large group of veteran hearing-aid users under the age of 6 are now giving direct evidence that children with serious hearing impairment can and do learn language and speech if an appropriate program is launched early enough and is followed through in the formative years.

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[1] Pauls, Miriam D.; Hardy, William G.: Hearing impairment in preschool-age children. The Laryngoscope. 63: 534–544, June 1953.

UNPROTECTED ADOPTIONS

MARGERET A. THORNHILL, M. S., Special Consultant, Division of Social Services, Children's Bureau

ADOPTIONS ARE POPULAR. Witness the interest the word arouses, in the press, radio, TV, and in any conversation. This widespread interest reflects a drastic change in attitude during the past 2 or 3 decades. For the most part this change is all for the good. To be an adopted child now is to be accepted and approved, and perhaps this is even more true of adoptive parents. On the other hand, a few years ago, an adopted child was more likely to be suspect, pitied, or expected to be eternally grateful for his good fortune.

Popularity has brought with it problems of supply and demand. Since the great demand is for young white babies, the Children's Bureau's explorations were concerned primarily with these babies. The number of such infants available for adoption has increased in recent years, but the rate of increase has not kept up with the demand.

One of the outgrowths of this imbalance between the number of couples who want to adopt and the number of babies available is a practice commonly referred to as the "black market"—the selling of babies for adoption. There is room for wide difference of opinion and judgment on many aspects of adoptions. But the idea of selling babies is intolerable. Nevertheless, the practice continues.

Socially abhorrent as the black market is, there are other adoption situations in which money is not the prime factor, but which expose children to preventable hazards of indiscriminate handling.

When we started our explorations we had no evidence that the black market involved large numbers of babies. What was known about it was serious. But so were conditions surrounding other children being placed by individuals. What we needed most was more information.

I started out by visiting two areas where a black market was known to have existed—New York and Florida. I also visited Tennessee where the head of a social agency had placed children for profit; Chicago and Detroit where the public was aroused about the way in which some adoptions were being handled; and Wisconsin, where medical, legal, and social protections of adoptions were reported to be good.

I talked with directors of public welfare and their staffs, heads of voluntary adoption agencies, directors of maternity homes, public health personnel, judges, law-enforcement officials, doctors, and lawyers in private practice.

I also had access to a great deal of information gathered by a former assistant district attorney in New York City who took part in the prosecution of several black-market rings.

The Child Welfare League of America is conducting extensive research into the practices of adoption agencies. The results of its efforts will go a long way in making known the conditions that surround children and parents served by social agencies. Our concern has been primarily with those mothers and

Evidence of a reprehensible traffic in babies in various parts of the United States prompted the Children's Bureau to undertake an inquiry into unprotected adoptions a year ago. This article, which gives the highlights of the findings, launched the discussion of a conference on "Protecting Children in Adoption," sponsored by the Bureau, in Washington, June 27–28, and attended by representatives of 32 national agencies in the fields of law, medicine, and social work. A report on the conference will soon be available.

children who do not get to a social agency.

Four themes will run throughout this report:

1. Every adoption involves a threefold interest—the child, his natural and his adoptive parents. Measures that protect one protect the other two. And if the interests of one are neglected, the interests of the others are in jeopardy.

2. Knowledge of community resources in the hands of those people in a position to give advice assumes major importance.

3. Prompt handling of the immediate needs of the unmarried mother may determine whether she arrives at an acceptable solution to her dilemma. These needs are for medical care and for help with her own reactions of guilt and the remorse she is very likely to feel.

4. Every mother who relinquishes her child for adoption, every child adopted, every couple who adopts a child, needs medical, legal, and social services. These services cannot be given in isolation. Each becomes most effective when given in coordination and harmony with the other. And conversely, any one provided without the other two leaves the people involved exposed to hazards.

Supply and Demand

All of us know that the demand for babies exceeds the supply. No one has yet figured out how to measure the demand. A frequent estimate by social agencies is 10 requests to 1 placement. Probably this estimate includes duplications.

Unquestionably, there are people who want to adopt children who cannot get one through a social agency. There aren't enough babies who meet their requirements. There are other reasons too. One of them is age. More and more agencies are choosing to place infants with couples under 40. And most agencies place children with couples of the same religious and similar racial and cultural background. Some States require such practices.

Moreover, agencies place only a limited number of babies directly from hospitals. Many agencies are now setting the goal of 3 months for placement of all babies, but some couples choose an independent arrangement for a newborn infant in preference to waiting for an agency baby.

One group that has special difficulty getting children for adoption through an agency is composed of couples associated with the armed forces. These people often are not in one community long enough

Every child needs the security and love of a normal family, agreed the recent Conference on Protecting Children in Adoption. Protection requires that adoptive parents be selected for their ability to provide these emotional needs.

to make up their minds they want to adopt a child, file their application, have their home studied, receive a child, and complete the adoption before they are transferred. Because agencies are faced with many decisions as to how to use limited staffs in selecting homes for children under their care they usually choose to allocate staff time to couples with stable residences.

Probably a direct result of this practice is the increasing number of members of the armed forces who are adopting foreign children—as are many other American families. Intercountry adoptions again bring supply and demand into the picture. There are children in Europe and Asia who need new families but meeting the demand for children through this source of supply is not as simple as one man thought it could be. He wanted to charter a plane, fly about 60 babies to this country from Korea and pass them out to any couple who subscribed to his delivery service.

Adoption of foreign children can be the answer for some people. Our concern is how these people, children and parents alike, can be assured the same protections we want for adoptions within our own country.

The Unmarried Mother

Any discussion of adoption immediately leads back to the unmarried mother. Seventy-two percent of the children adopted by nonrelatives in this country

are born to unmarried mothers; 150,000 mothers each year give birth to a child out of wedlock; 54,000 are white; 96,000 are nonwhite.

What happens when an unmarried girl suspects she is pregnant? She may refuse to face the possibility and postpone confirmation by medical examination as long as possible. A considerable number of girls actually wait until time for delivery before they seek medical care.

The girl's first step toward advice or help is a vital one. Her actions are controlled to a large extent by the degree of her desire to keep her condition secret. Certainly her knowledge of community resources, or lack of it, will influence her selection of the person or agency to which she will turn first.

One of the first considerations for the girl seeking secrecy is to go where she is unknown. Many girls who leave home want to relinquish their children for adoption. They are looking for the answer to three questions: How to maintain themselves during pregnancy; how to obtain medical care; and what to do about the baby.

From the information available to us, unmarried pregnant girls are getting less medical care, and are getting it later in pregnancy, than married women.

A study made in 1954 in New York City of 154,165 mothers, 8,344 presumably unmarried, showed that by the end of the sixth month of pregnancy, 87 percent of the married mothers had made a prenatal medical visit, as compared with 47 percent of the unmarried.

Four percent of the married women had had no prenatal care, whereas 23 percent of the unmarried women had had none.[1]

Data on premature births and infant mortality suggest further correlation between marital status and medical care. A notably higher percentage of births out of wedlock occur outside of hospitals,[2] and higher rates of neonatal mortality—deaths under 28 days are associated with nonhospital deliveries.[3]

Another important factor is the age of the mother at the time of childbirth. Mortality rates are considerably higher for mothers under 20 than for those between 20 and 24. Some 62,000 mothers under 20 years of age give birth to a child out of wedlock each year.

More research is needed to establish fully the relationship between marital status of the mother, and the extent and timing of the medical care she receives. That the unmarried mother is presently receiving less than she needs, and that there is a direct relationship between this fact and her unmarried status, seem clear.

The unmarried girl must face her own inner feelings as well as the outward reactions of society. If she must also face real difficulty in getting medical care and shelter, she is indeed under serious pressure. For those girls who do get to a social agency early and are offered the kind of help they can use, the pressure is considerably diminished.

Our immediate concern is with those girls who turn to individuals for help. Who are these individuals? They can be any friendly person who will listen to the girl's story. Many of them are people who, because of their profession or because of their position in the community attract the confidence of the unmarried girl—a clergyman, a doctor, a lawyer, a public-health nurse, a schoolteacher, or an employer. We have been told that often this first person is a druggist, possibly because the pregnant girl first thinks of abortion. What the pharmacists know about these girls is still one of our unexplored areas.

How do these people respond to an unmarried pregnant girl's request for help? How can they know how to advise her, and to guide her to resources that will help her handle all the problems involved in being an unmarried mother? Frequently, they do not themselves know of community resources. And all too often, community resources do not exist that will meet the particular needs of the particular unmarried mother.

Community Resources

Data are not available to show the nationwide picture of community resources. However, voluntary and public agencies invariably report inadequate funds and insufficient staff to offer medical care and social services needed by unmarried mothers and their children.

Residence requirements assume great importance in the whole adoption picture in view of the fact that a large number of unmarried pregnant girls leave their home States. Many States and local communities put restrictions on the use of their free services by nonresidents. These may take the form of requiring some clearance with the girl's home State, or some contact with her parents to see if they can assume financial responsibility. The girl's desire for secrecy may prevent her from accepting service under these conditions.

Some Community Chests have urged their member agencies to restrict their services to residents. Some agencies will accept the baby for adoptive placement,

but cannot offer the mother any kind of maintenance other than in a maternity home or a wage home. Few agencies have money to pay for private medical care, even though the private physician may have referred the girl to them.

Behind these restrictions on the use of free services by nonresidents lie several explanations. Medical or any other kind of help, some people believe, should not be made easy for these girls, lest it encourage illegitimacy. Some communities fear that if they open their services to all comers they may attract too many and become overburdened with the expense.

One of the most frequent reasons for restrictions is the fear that the child will not be adoptable, and will become a longtime charge on the community or the State. So an effort is made to establish financial responsibility in the State of the girl's residence.

Individual Placements

But agency practices *are* changing, as their knowledge and experience grow. Unfortunately, unmarried mothers and the community do not always know of these changes, and some agencies do not change very fast. If an unmarried mother thinks she will have to give information to an agency about her place of residence and her family, or that she will have to continue some responsibility for the child until he is placed for adoption, an individual's offer of maintenance and medical care with no questions asked may seem preferable. What she often fails to realize is that with such an offer, she must pay a price, a price she is not prepared to evaluate at the time—her child.

We know that usually one of the first concerns of an unmarried pregnant girl is medical care. Naturally she turns to a doctor. The childless couple turns to a doctor for help in getting a baby to adopt. The doctor naturally thinks first of the well-being of his patient. The pregnant girl and the childless couple may be his patients. He may look upon adoption of the child as a way out of an embarrassing situation for the girl, and a way to happiness for the couple. What the child may need can be lost sight of in concentrating on the needs of the patients. We know that some adoptions arranged by family physicians are successful. However, I have been told of doctors who are obtaining babies for couples who are not their patients and whom they do not know.

I have had a number of doctors tell me of a couple who has come to them because they do not have children. The wife is distraught. Her desire for a child has become an "obsession." Doctors have told me they feared the wife would have a mental breakdown if she did not get a child. And they have helped her to get one.

The unmarried mother may be directed to a doctor known to welcome such patients because he has found that adoptive couples are more than willing to pay whatever professional fee is asked in order to get a baby. Similarly, unmarried mothers may be directed to certain lawyers who are eager to act as intermediaries in an adoption.

State Legislation

State laws affecting children going into adoption are scattered throughout the statute books. Besides laws that apply to the procedure of an adoption petition through the court, at least four other kinds relate directly to adoption and to the three parties to it:

1. Laws relating to voluntary and involuntary termination of parental rights.

2. Laws relating to relinquishment and the right to consent to adoption.

3. Laws relating to the licensing of child placing agencies, foster homes, and maternity-care facilities.

4. And laws specifying who can and who cannot place a child for adoption.

Every State has developed its own particular legislative framework surrounding adoptions. The points at which the forces of protection of children are brought to bear vary with States and communities. In some communities the case of every unmarried pregnant girl who is a minor is subject to review by the court or some authoritative agency to determine whether she is in need of special protections. Some States seek to protect the child born out of wedlock by requiring that the birth be reported to the department of welfare.

Other States bring their protective forces to bear at the time the child is placed in the adoptive home by requiring that the placement be made by a person or agency licensed to do so. Others require investigation after the adoption petition has been filed and after the child may have been in the home some months.

Obviously, with all these variations in State laws regulating adoptions, the opportunity for evading any one or all of them is open to any person who wants to do so—especially where there is no agency

that has been designated to enforce the protections.

Take for example, the filing of adoption petitions. Some States require that these be filed in the petitioners' State of residence. Usually an accompanying law requires a social study of the petitioners' home. Such laws give importance to establishing the suitability of the couple to adopt a particular child.

Other States have no such requirements. Any couple may file a petition to adopt a child without regard to their residence. This means that a couple found unsuitable to adopt a child in their home State might obtain one in another, file their petition, and return home with the baby.

Areas for Consideration

While many honest differences of opinion exist as to the criteria for selecting adoptive parents, most people would agree that some couples who want to adopt a child are not suitable prospective parents. Serious consideration must be given to how children can be protected from adoption by couples who can neither offer the child a reasonably happy future nor achieve happiness for themselves by this route.

One desirable protection for all parties in an adoption is that, once it has been completed, the child not be disturbed by having two sets of parents. The safest way to prevent this is to provide for termination of parental rights and placement of the child in such a way that the natural parents do not know where the child is placed. Some statutes prohibit placement by other than an authorized agency, but exempt the mother from this prohibition. This, while recognizing certain parental rights, has inherent dangers for all concerned and calls for a careful examination of the philosophy of the law to see how it can insure the rights and responsibilities of all—the child, his natural and his adoptive parents.

What often happens is that, despite a prohibition against individual placements, an unauthorized intermediary takes over, ostensibly acting for the mother. Often a person who knows of an unmarried mother seeking to relinquish her child and a couple wanting to adopt one acts as the arranger between the two parties. The intermediary often defends this practice on the grounds that he is protecting the child and his adoptive parents. This is one of many situations in which the independently arranged adoption is only made by evasion, manipulation, or actual violation of the law.

Two kinds of situations are being reported with sufficient frequency to give reason for grave concern. One is the registration of the unmarried mother in the hospital under the name of the adoptive mother. Presumably the child is reported as being born to the "adoptive" mother and therefore is never adopted. This means falsification of the birth record. The child is left without a clearly defined legal status. How can the parents live but in fear that the falsification will become known? No matter how much a child is treated as the parents' own, the fact that he is not is known to the people in whom the child is most likely to sense fear and uneasiness—his parents. Such children are very likely to learn of their status sooner or later. Experience is overwhelmingly in favor of the adopted child learning from his adoptive parents his status in the family.

Another kind of legal situation with inherent problems is that of the married woman whose husband is not the father of her child. Usually such a child is recognized as legitimate unless proved otherwise, and therefore the husband's consent to the adoption is required. If the mother does not want her husband to know about the child and wants to release him for adoption, she faces legal as well as emotional problems. Women in such difficulties have turned to the black market and to others who are unconcerned with such legal requirements. Certainly the best legal and social thought is needed to find a way of dealing with such situations.

Many abuses have been reported around a mother's relinquishment of her child. Some of the most vicious cases that have come to light from the black market are those in which a girl has been frightened or coerced into signing a relinquishment before or immediately after delivery.

Contested Adoptions

Frequently newspapers carry stories of contested adoptions. The natural or the adoptive parents are dissatisfied with the arrangement. These cases are tragic in the damage and hurt they cause. They are comparatively few out of the total number of adoptions, but there are many more cases in which great harm is done that do not make the headlines.

A young girl from a small town in Kentucky went to Detroit when she found she was pregnant. She told her family she had a job there. She found a friendly druggist who could not help her with her first question, but offered to get her to a doctor who would give her medical care. The doctor assured her of maintenance, medical care, and sufficient money to start her on her way after the birth of her child. He knew of a couple who would pay all these expenses if they could have the baby.

Detroit rigidly enforces a law that in any independent adoptive placement the home must be studied before the child is placed in it. This means that the baby must first go into a temporary boarding home until a report is made to the court on the suitability of the adoptive home.

The girl delivered her child, was visited by the attorney of the adoptive couple, left the hospital, signed a relinquishment, and returned to her home saying only that she did not like working in Detroit.

The baby was taken to a temporary home to await the report to the court. In the meantime, the adoptive couple's own doctor examined the baby and found him to be abnormal. The couple refused to take the child. The attorney got in touch with the girl at her home and told her she would have to come for her baby. Even though she had signed a relinquishment, she was still legally responsible.

Sometimes the situation is reversed. The adoptive couple takes the baby and is extremely happy with him. It is the girl who changes her mind. If her rights have not been terminated, and if she knows where her child is, she may contest the adoption, with tragic results for everyone concerned.

Can such contested adoptions be prevented? For the most part, yes. If the mother is helped with her emotional problems at the time she must make the decision to keep or to give up her child, she is very likely to make a decision she can live with.

One of the most frequently reported characteristics of individuals who arrange adoptive placements is their lack of concern with the future of the natural mother. Besides humanitarian interest in helping girls in trouble, another important reason exists for being concerned about their future. Most of them are in the early years of their childbearing period. Most of them will have more children, hopefully in wedlock. The community has a real stake in helping these girls become stable wives and mothers.

Federal legislation has been suggested aimed at preventing and controlling the black market. These proposals would make it a Federal offense to transport a mother or a baby across State lines for the purpose of selling the baby for adoption.

The little specific information we have on black-market operations indicates that the interstate movement of the mother is voluntary and not controlled by the black marketeer. The transporting of the baby is by the adoptive couple. Therefore, the proposed legislation would not be effective in controlling the activities of the intermediary. True, one of the black-market rings that was exposed and prosecuted involved the transporting of babies from Florida to New York, but we have no recent information that any such rings are in operation.

One kind of suggested Federal legislation would make it an offense to transport a baby interstate in violation of the laws of the States involved. Where State laws are weak, such a Federal law would be ineffective. It would, however, keep responsibility within the States, and might be used to urge States to strengthen their laws.

A Community Responsibility

Inherent in the effectiveness of the law is the community's attitude toward it. If the community does not know about the law, or knows about it but does not accept it, or accepts it but will not give money for the services required, the protections provided by the law can have little effect.

Twenty thousand children a year are placed with nonrelatives by individuals for adoption. We do not know how many of these children lack adequate protections. We need to find out. But even more we need to find out what protections are essential and how they can be obtained.

Until the professions which are directly concerned can arrive at a consensus of what medical, legal, and social protections are needed, there seems little hope that the black-market and other unprotected adoptive placements can be prevented.

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[1] City of New York Department of Health, Bureau of Records and Statistics. Unpublished statistics based on material from confidential birth certificates. 1954.

[2] National Office of Vital Statistics, Public Health Service, Federal Security Agency: Report on illegitimate births 1938–47, vol. 33, no. 5, Feb. 15, 1950.

[3] ———, Department of Health, Education, and Welfare: Weight at birth and its effect on survival of the newborn in the United States, early 1950. Vital Statistics Special Reports, vol. 39, No. 1, July 23, 1954.

Are programs of parent education reenforcing or undermining parents' confidence? An expert discusses . . .

THE CRITICS AND PARENT EDUCATION

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IS THERE an anti-expert trend in parent education? Some people say there is. I for one do not know. Certainly there is a great deal of criticism. But is it proportionately greater than heretofore? I say "proportionately" because there is so much more parent education than there used to be, that perhaps it is only natural that there should also be more criticism. Granting that there is a lot of criticism, what are the reasons?

In trying to analyze reasons, perhaps a little speculation about the motives of the critics is relevant. Some of them I am convinced are critical out of genuine humility. They are impressed by the intuitive wisdom of many parents; they are aware of their own fallibility; more and more they challenge their own assumptions; and presently they get caught up in an excess of doubt which expresses itself in pronouncements to the effect that "Nobody knows anything about anything." A certain amount of this attitude is healthy. Too much almost surely leads to confusion and defeatism.

Some critics make sweeping indictments but fail to think through the implications of their recommendations. "Let parents alone," they say. Does that mean, then, that we should make no effort to pass on today's new knowledge? "Parents are confused" is one of their war cries. Incontrovertible. But does that mean parents should not be exposed to new ideas? "The wisdom is within the group." But how about the errors? They are within the group too.

Some criticism of this kind is sincerely intended to be constructive, and may indeed prove to be so at times, but some of it is clearly hostile and destructive.

Some people do not have the skill to build up, and so they tear down. In this category I would place the headline seekers. If they cannot get attention from their own work, they will get it by pointing out flaws in the work of others. When a job is hard to do, as is parent education, it is always easier to point out what is wrong than to set about trying to do better. The pointer-outers can usually count on the enthusiastic support of the press, which is never so happy as when it can report that someone "blasts" or "flays" someone else—preferably another "expert." Some newspapers may even give a little twist here or a mite of distortion there, or lift a point or two out of context, in their search for "news" or an "angle" playing up an apparent row between experts. There is always a sizable segment of the reading public that glories in the deflating of any kind of so-called expert, particularly if that person has the temerity to claim any special knowledge about children. Doesn't every adult secretly regard himself as an expert on this subject?

How To Evaluate?

Apparently, then, there are more than a few reasons why parent educators might as well expect to come in for rather more than their share of being taken to pieces. What they want to know is how to decide how much criticism to take seriously and how much to shrug off. That brings us to some key

questions about how they can measure the value of what they are doing.

Conscientious parent educators strive hard to improve their work. They are convinced that what they are trying to do is worth doing. They usually have a feeling of accomplishment. But that does not mean their heads are in the clouds. They are capable of self-criticism. They are willing to examine themselves. If their methods are not effective, they want to know it. If their materials are not valid, they want to know that. *How are they to judge the effectiveness of their work?*

This question puts us squarely in the middle of the evaluation problem. What *do* we know about what parent education accomplishes? How *can* we tell which work is worth the effort and which is not? Although sounding fairly simple, these are among the knottiest questions we are facing today. When it comes to matters psychological and things having to do with the interpretation and modification of human behavior, we are all more sophisticated than we were a few years back. We are less starry-eyed about our own new ideas. We are eager to differentiate between wishful thinking and proof. We are less willing to depend on opinion, even when it represents a consensus of thought.

But I for one am rather discouraged about studies of evaluation. When I see them in the literature, I reach for them eagerly. I keep hoping somebody will have evolved a brilliant new technique I have never heard of. Too often, however, so-called "evaluations" turn out to be simply another array of opinions. Or if they pretend to some degree of objectivity, then often it seems as if the investigators, in an effort to control the multiplicity of variables, have squeezed all the "value" out of "evaluate."

In another article[1] I have grappled with the problem of criteria of effectiveness. Frankly, they are not impressive.

Current Criteria

Two major criteria are in everyday use, whether consciously or not. The first is popularity, or demand. If a piece of material—a book, a film, a lecture, a radio program—is well liked by the public for which it is intended, there is often a blind assumption that it is therefore effective and accomplishes the purpose it sets out to accomplish. A moment's thought shows that this is not necessarily true. Because something is popular is no proof that it is effective. However, if it is *not* popular, then it is definitely not effective—a point too often overlooked by ivory-tower scientists and educators who do not like to be bothered trying to make their material understandable.

The second criterion on which we lean heavily is the opinion of authorities. The unreliability of this criterion is never so apparent as when authorities differ among themselves. Even when they agree, we rarely have the kind of proof that will stand rigid tests of scientific validity.

In spite of this, I happen to think than when these two criteria are put together—popularity, or demand, and the opinions of authorities—we have at least a reasonably good guide as to value. Pernicious stuff may be popular, but it will not be approved by really thoughtful and experienced authorities. Dull, incomprehensible stuff may be approved by authorities, but it will not be well liked, and therefore will not be used. When a piece of material or a technique is both approved by those who have given the subject the most study, and well liked by the audience for whom it is intended, the chances are that it has a certain amount of value.

Increased Sensitivity

When I feel frustrated at our inability to *prove* the value of parent education, I take consolation in my conviction that we are moving on a desirable course. When you are on a strange country road you do not have to know where you are at every moment if you are reasonably sure you are going in the right direction. I feel that we are moving ahead because I have confidence in our steadily increasing body of knowledge about people.

We are far more sensitive to many things than we were 20 or 30 years ago. For instance, we are more sensitive to the potential gap between learning and teaching. We are less willing than formerly to assume that any person, whether child or parent, is learning what we are trying to teach. We are not satisfied to sit back and say "This is what I am teaching." We see the necessity for turning the spotlight on the question "What is that person really learning?" (What a shock it is sometimes to find out!)

We are more sensitive than we used to be to the many factors that enter into the learning situation: to motivation and identification and resistance; to readiness and timing; to anxiety and unconscious feelings. True, there are also some things about which we are not nearly sensitive enough, such as the futility of exhortation, and of admonishing parents to change their feelings and their character structure.

We are more sensitive to the fact that there are

different *kinds* of learners. We can almost visualize a sort of readiness-resistance scale of learning, with a parent's standing on this scale determining what and how much he is able to absorb in any parent-education situation.

I like to think of parents as roughly divided into "levels of readiness." The first is the level of "simple ignorance." The parent—let us say a mother—does not know certain things about children which she wants to know. She is ready and eager to learn. When she is told things, she understands. She uses what she has learned. Because her mind is open and receptive, she needs only to be exposed to good parent education.

A second level of readiness is represented by the kind of mother whose ignorance consists not merely of naive "not knowing" but of knowing the wrong thing. A mother of this type is apt to be resistant to new ideas, set in her ways, full of faulty notions. She will not learn nearly so fast as the first mother, but neither is it impossible to teach her under the right circumsances. Mere exposure to parent-education materials is unlikely to be enough, but she is reachable if the techniques and content are tailor-made to her requirements.

The third level of readiness, or rather of unreadiness, is represented by the mother whose ways of thinking and doing things are traceable to anxiety and emotional disturbance. This mother may not be reachable at all by ordinary methods of parent education unless it is possible first to deal with her own personality problems.

Professional people who are accustomed to dealing primarily with but one of these types of mothers sometimes generalize erroneously from their experience. For instance, clinicians who spend most of their time seeing only mothers with personality disturbances are likely to say "Nobody learns from reading." True, most mothers in the third category are unlikely to learn from reading. But this is not necessarily true of the mothers in the first category, many of whom get a great deal from reading.

A similar mistake is sometimes made in the opposite direction. Professional workers who are accustomed to dealing with young mothers who are reasonably well adjusted and eager to learn, may surmise that all you have to do in all cases is to point out mistakes or *tell* them something and they can absorb it. With the third category of mothers, "telling" is notoriously ineffective; with the first it may be all that is necessary. When these differences are recognized, materials and methods can be adjusted accordingly. These points about levels are developed more fully in "Health Supervision of Young Children." [2]

Continuous Assessment

Let us return to the question of how parent educators are to judge the effectiveness of their work. I have been trying to answer this by squarely facing the fact that up to now we have few if any real measures of effectiveness. We are rarely able to say "such and such is a good method and here is the proof." Instead we are nearly always obliged to rely on the combination of demand and opinion. They may give us a *guide* as to *probable* value, but they do not give us *proof* of value.

Although it seems painfully unscientific to say so, I have gone out on a limb and declared myself as thinking that under the right circumstances the combination of these two criteria—demand and opinion—gives a reasonably good guide to effectiveness. Moreover I have admitted to a personal conviction—unproved to be sure, but deeply held—that we are moving in the right direction in increasing our body of knowledge about children and families and behavior. Since much of this knowledge takes the form of increased sensitivity to the many factors affecting learning, I believe that as sensitivity increases, effectiveness in parent education will also increase. The criticisms of the "anti-experts" should be weighed thoughtfully, to see what we can learn from them, but should not be allowed to undermine the confidence of parent educators in their own work.[3] The important job is to assess what we know and what we do not know in parent education, and keep moving in the directions that we think are right.

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[1] Ridenour, Nina: Criteria of effectiveness in mental health education. American Journal of Orthopsychiatry, 23: 271–279, April 1953.

[2] American Public Health Association: Health supervision of young children; a guide for practicing physicians and child health conference personnel. New York. 1955. pp. 180. See pp. 44–47.

[3] Ridenour, Nina: Code for Snipers. *In* children here and now: notes from 69 Bank Street. 1954. p. 4.

An essay review . . .

JUVENILE DELINQUENCY AND *ANOMIE*

HELEN L. WITMER, Ph. D., *Director, Division of Research, Children's Bureau*

ONE of the most provocative discoveries to be made about juvenile delinquency in recent years has emerged from an analysis of court statistics and census-tract data in Baltimore. The report of this study, "Toward an Understanding of Juvenile Delinquency," by Bernard Lander[1] is important not only for what it tells about juvenile delinquency and the author's explanations of his findings but also for what it shows about the way he arrived at his discovery. This method, in fact, may be its most important contribution, for it is a warning that there is no short and easy way to determine the significance of the facts that are represented by some of the most familiar statistics of social work.

Lander's study is based on the juvenile-court statistics of Baltimore for 1939–1942. In those years 7,193 different children appeared before the court in 8,464 official hearings. This represented an annual rate of court appearance of about 10 per 1,000 population 6 to 17 years old.

Delinquency (defined as court appearance) was more frequent among boys than girls and among Negroes than among white children. During this 4-year period something like 40 percent of the Negro boys 14 or 15 years old appeared before the court and 26 percent of those who were 10 to 13 years old. For white boys the corresponding figures were 12 and 7 percent respectively.

Delinquency, as expected, was much more frequent in some parts of the city than in others. Several census-tract areas sent no children to court during the 4 years under consideration, while in one tract the average delinquency rate was 21 per 100 children.

The areas of the city where the delinquency rate was high were characterized by substandard housing, overcrowding, lack of home ownership, a low level of education. In short, they were poverty-stricken areas.

So far, it is the old story. But is it the whole story? Is there really such a close connection as is usually supposed between juvenile delinquency and these often-observed facts of economics and race? The answer in Lander's study is no.

The purpose of this article is to show how Lander arrived at that conclusion, what factors he did find significantly related to delinquency, and what this implies for delinquency research.

The Method

The measurement of the amount of association among variables is the statistician's job, and for that measurement the modern statistician has several tools. The tool he has most frequently used in analyzing delinquency statistics is simple "zero-order" correlation. By this means the association between an individual variable (such as race or degree of overcrowding) and delinquency is worked out. This result leaves unanswered the question of how closely the different variables are themselves associated—for example, how closely race and income and kind of housing and amount of education are connected, and whether their connection obscures the influence of any one of them on delinquency. The statistician, however, has other, more refined methods of analysis that he can, and should, use in studying such complicated interrelationships. What happened when

Adapted from a paper presented at the 1955 forum of the National Conference of Social Work, San Francisco, Calif.

these methods were used in the analysis of the Baltimore figures is the gist of our story.

The first point to be emphasized in telling that story is that this study dealt with census tracts—the 155 of them that compose the city of Baltimore—rather than with individuals. In other words, the question under consideration was how closely a tract's delinquency rate was paralleled by its rate of inadequate houses, Negro population, or other trait, and which factors on the list of variables were most closely associated.

The second point to be made concerns the list of traits studied. Limited to factors about which information existed in statistical form, they were: (1) proportion of children delinquent; (2) proportion of population nonwhite (racial heterogeneity); (3) proportion of foreign-born; (4) median years of school attendance; (5) median rental; (6) proportion of substandard houses; (7) proportion of overcrowding; (8) proportion of homes occupied by owner.

Now, what was discovered about the relations between these traits and delinquency?

First, when the simple correlations between the delinquency rate and other traits were worked out one by one the usual findings emerged. There was a high association between each of these traits (except percentage of foreign-born) and delinquency:

1. Percentage of homes owner-occupied	−.80*
2. Percentage of overcrowding	+.73
3. Percentage of nonwhites	+.70
4. Percentage of substandard housing	+.69
5. Median rentals	−.53
6. Median school years of education	−.51
7. Percentage of foreign-born	−.16

This is where most statistical studies stop—except that the writers may go on to compound the error of inadequate statistical analysis by drawing erroneous conclusions—for instance, that poor housing causes delinquency. Correlation, it may be said parenthetically, does not demonstrate cause under any conditions, whether the statistical method used is crude or refined. It only shows that two things go together—and this may be because they are both influenced by a third thing, or by nothing at all.

Lander went further in his statistical analysis by correlation method for at least two reasons. First, in social phenomena there is seldom a simple relation between two traits, such as delinquency and race. Usually many other traits are involved, which themselves affect each of these two variables. Second, the product-moment method of correlation used to obtain the findings cited above assumes that a linear relationship between the two variables exists—for instance, that the poorer the housing or the higher the proportion of Negroes in an area, the higher the delinquency rate. Close inspection of the data broken down into subgroups showed that this assumption was not always justified.

For example, it was found that up to a certain point the delinquency rate increased as the percentage of Negroes increased. But when the percentage of Negroes reached 50 percent the delinquency rate began to go down. In areas predominantly Negro, the delinquency rate was no higher than in corresponding white areas.

Data Analysis

This being so, Lander moved on to analyze his data by a process called partial correlation. Partial correlation is a method by which the association between delinquency and another trait, such as substandard housing, can be measured, with the influence of the other factors—race, education, and the others—being excluded.

In addition, Lander adjusted his partial-correlation coefficients to take account of the fact that the relationships were not linear.

The findings that emerged from these two operations greatly changed the conclusions about the association between delinquency and the variables under consideration. This analysis indicated that when other traits were held constant, instead of a high relationship, no relationship existed between delinquency and substandard housing and overcrowding. Only two traits stood out as being significantly related to delinquency in Baltimore: the racial heterogeneity of an area and the percentage of homes that were rented instead of owned.

As a check on these findings and in an attempt to learn more about the implied relationships, Lander then decided to use another tool of statistical study, factor analysis. This is a method by which one can determine whether there is an underlying order among a series of variables; that is, whether some groups of them do and some do not go together. In particular, his interest was in seeing in which group of associated traits, if any, delinquency belonged.

*A perfect correlation is 1.00. "Plus" indicates that the traits—for instance, delinquency and overcrowding—are positively associated; "minus" that they are negatively associated—for example, the more delinquency, the fewer homes owned by the occupants.

Through this kind of analysis, Lander found that the traits he was studying exhibited two groupings, with one trait—percentage of foreign-born—not belonging to either group. One group consisted of four traits: median rental, percentage of overcrowding, percentage of substandard housing, and median years of schooling. The other consisted of three traits: degree of racial heterogeneity, percentage of homes owner-occupied, and the delinquency rate. The two sets of traits were apparently related to each other but only in the second set was the delinquency rate found.

The Interpretation

What does this mean? The variables being studied were obviously not factors determinant of delinquency in and of themselves. They were only descriptive figures, or indices of something or other. All the analysis showed was that in Baltimore's census tracts, on one hand, low rent, overcrowding, substandard housing, and little schooling went together; on the other, a high proportion of racial heterogeneity, a low proportion of homes occupied by their owners, and a high delinquency rate went hand in hand. And, to a certain extent, the tracts that had one of these sets of traits also had the other set of characteristics.

What underlies each of these sets of traits; what is it that they are pointing to? The answer cannot be determined by statistics. It calls for logic, the application of previous knowledge and theory to the situation at hand.

Lander conjectures that the first set of traits evidences an economic factor at work, and that the second set—the proportion of Negroes in a tract, the proportion of homes occupied by the owner, and the delinquency rate—indicates what certain sociologists have called *anomie.*

Unfortunately for research, *anomie*—normlessness—is a rather vague term. It was first used in modern times by the French sociologist Durkheim [2] in a brilliant, highly suggestive study of suicide. Parsons [3] and Merton [4] have picked it up and elaborated upon it. The term refers to the condition of social disorganization or social instability in which the power of social norms to control the conduct of individuals is slight—perhaps because the norms (the rules of the game in social life) are not clearly expressed or firmly implemented or sharply because conflicting norms obtain in the area under consideration. This condition of normlessness leaves people at loose ends, not knowing how they ought to behave and often not caring. That it would lead to delinquency on the part of many youngsters—as well as perhaps apathy, confusion, or disgust on the part of others—seems theoretically at least, obvious.

Lander's thesis is that, in Baltimore, neighborhoods characterized by a high proportion of rented homes and a high degree of racial heterogeneity are the ones most likely to be disorganized, unstable, lacking in a clear sense of social values. This would not necessarily be true of other cities. For them, some other indications of normlessness might have to be found if one wanted to see whether delinquency and *anomie* go together.

For Baltimore, however, he concludes, that the chief explanation of the differences among census tracts in rate of delinquency is to be found not in economics but in social organization. More children become delinquent in certain parts of the city than in others not because money is scarce but because social life is disorganized. Children cannot regulate themselves in accordance with conventional norms when those norms are vague or dimly formulated in the social group (family and community) in which they live or where there is a conflict of norms with no clear consensus as to which are right. This normless condition is more likely to obtain in the slums than in the suburbs but it is not a necessary concomitant of poverty; nor, we might speculate, is it necessarily absent under conditions of wealth.

Directions for Research

This last observation leads to my next point: Where do we go in further research? Obviously, the first thing to do is to check upon the validity of Lander's findings. Do the statistics of other cities tell the same story? In cities unlike Baltimore in racial heterogeneity and home ownership are there other indices of *anomie?* In any city, what additional data indicative of social instability might be adduced that would serve as a check on these findings?

Second, what about *anomie* itself? Can it be better defined? If it does exist, by what is it indicated? What are the signs and symptoms of this sickness of the social soul?

Third, if *anomie* can be operationally identified, will it be found to exist in certain more prosperous segments of society also? Does it correlate with the incidence of behavior disorders, if not of official delinquency, among children in such areas?

Fourth, if this discovery of an association between normlessness in an area and delinquent conduct on

the part of its inhabitants is confirmed by other studies, what is the process by which the one leads to the other in the individual case? Sociology and psychiatry already give hints as to the answer but much more detailed analyses of individual, family, and community histories will have to be made before the dynamics of the process become clear.

So much then for some ideas about future research. As to implications for prevention of delinquency, they can be drawn only on the assumption that this one study proves the point. Without claiming that this is so, but rather affirming that research and practice should go hand in hand, I would suggest that this study bolsters the claims of those who seek delinquency prevention in community reorganization, in the reaffirmation of moral values, in the practice of genuine democracy throughout our society, in any and all measures that give parents and children a clear sense of social direction and purpose. If measures looking to these ends can be devised and carried out, their effects on youthful conduct will provide the best test of the correctness of Lander's hypothesis.

[1] Lander, Bernard: Toward an understanding of juvenile delinquency. New York: Columbia University Press. 1954. 143 pp. $3.

[2] Durkheim, E.: Division of labor in society, Translated by George Simpson. New York: Macmillan Co. 1933. pp. 297–301.

[3] Parsons, Talcott: The structure of social action. New York: McGraw-Hill Co. 1937. p. 377.

[4] Merton, Robert K.: Social structure and anomie. *In* Social theory and social structure. The Free Press, Glencoe, Ill. 1951.

Guides and Reports

CEREBRAL PALSY; methods of evaluation and treatment. George G. Deaver, M. D. Rehabilitation monograph IX. Institute of Physical Medicine and Rehabilitation, New York University-Bellevue Medical Center, New York. 1955. 57 pp. $1.

Latest of a series of monographs dealing with various aspects of rehabilitation and services to the handicapped. Presents information on the etiology, pathology, diagnosis, and types of cerebral palsy; also the methods which in the author's experience have proved most successful in meeting the total needs of the cerebral-palsied child and his parents.

A GUIDE FOR LEADERS IN PARENT AND FAMILY LIFE EDUCATION. Pearl T. Cummings, Dan C. Overlade, and Dale B. Harris. Institute of Child Welfare, University of Minnesota, Minneapolis. 1955. 77 pp. $1.

Outlines a course in local leadership for parent-education groups and gives detailed suggestions for using devices such as films and tape recordings. Includes in the content of such a course such subjects as parent-teacher relationships, self-reliance and responsibility, emotional development, adolescence, and sex education. Suggests practical steps for borrowing the 18 tape recordings prepared by the Institute.

ON CULTURAL FACTORS IN CASEWORK. Sol Wiener Ginsburg, M. D. National Travelers Aid Association, 425 Fourth Avenue, New York 16, N. Y. 1954. 19 pp. 35 cents.

Discusses the effects of culture on the social caseworker, the client, and the casework process. Some factors, apparently cultural, says the author, turn out to be highly personal elements in which the culture merely sets the backdrop for the acting out of the client's personal problems.

WORKING WITH THE CHILD AND HIS PARENTS. Child Welfare League of America, Inc., 345 East 46th Street, New York 17, N. Y. 1954. 23 pp. 60 cents.

Presents two papers, reprinted from the *Social Service Review*, September 1954: "The Casework Process in Working With the Child and the Family in the Child's Own Home," by Mary E. Rall, and "Treatment After Placement," by Esther Glickman.

WHEN PARENTS GET TOGETHER; how to organize a parent-education program. Gertrude Goller and a staff committee of the Child Study Association of America. The Association, 132 East 74th Street, New York 21, N. Y. 1955. 47 pp. 50 cents.

Advises parent groups on such points as how to get the education program started, what to do about publicity, how to use local and national resources, how to find and develop leaders. An appendix lists resources for program materials.

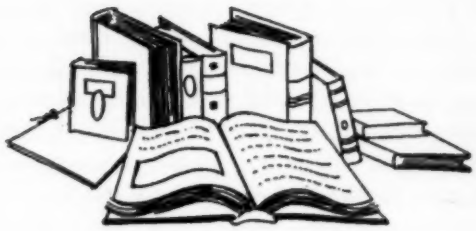
SAFEGUARDING THE EMOTIONAL HEALTH OF OUR CHILDREN; an inquiry into the concept of the rejecting mother. Anna Freud. Child Welfare League of America, Inc., 345 East 46th Street, New York 17, N. Y. 1955. 16 pp. 50 cents.

"Rejection" of a child by his mother, says Miss Freud, is a vague concept and through overuse has become almost meaningless. She defines various types of rejection growing out of a mother's unwillingness, her abnormality, her separation from her child.

INDIVIDUAL DEVELOPMENT. Lawrence K. Frank. Doubleday & Co., Garden City, N. Y. 1955. 52 pp. 85 cents.

Explores the development of the child and reviews some studies that show what is involved in individual development. Differentiates development according to the internal environment, motor patterns and locomotion, communication through language, and cognitive and symbolic processes.

BOOK NOTES



GROUP THERAPY FOR MOTHERS OF DISTURBED CHILDREN. Helen E. Durkin, Ph. D. Foreword by S. R. Slavson. Pub. 236, American Lecture Series, edited by Molly Harrower. Charles C Thomas, Springfield, Ill. 1954. 125 pp. $3.50.

This book tells how regular group meetings with a psychotherapist have helped mothers to gain insight into their attitudes toward their children. Over a period of about 15 years the psychoanalytically oriented method described has been applied to about 100 groups of mothers. In the future the author hopes to expand the work to include fathers.

GUIDANCE IN A RURAL-INDUSTRIAL COMMUNITY; Harlan County—A Kentucky coal-mining district plans with and for its boys and girls. Amber Arthun Warburton. Preface by Ruth Strang. Alliance for Guidance of Rural Youth and Department of Rural Education, National Education Association of the United States, 1201–16th Street NW., Washington 6, D. C. 249 pp. Paper, $3; cloth, $4.

Two decades of a guidance program in a mining community are described in the first part of this report. The second part records appraisals of the program by teachers, principals, the boys and girls themselves, parents, and others in the community.

GROUP WORK AND COMMUNITY ORGANIZATION, 1953–54; papers presented at the 80th and 81st annual forums of the National Conference of Social Work. Columbia University Press, New York. 1954. 104 pp. $2.25.

The nine papers included in this collection are addressed to supervisors, practitioners, and volunteers in the fields indicated by the title. Subjects include agency-intake practice, activities for disturbed children, community studies of living conditions, evaluating individual members of a group, similarities and differences between social work and education, measurability of need for social services, participation of official agencies in community programs, and international social action.

EXPANDING HORIZONS IN MEDICAL SOCIAL WORK. Edited by Dora Goldstine. University of Chicago Press, Chicago. 1955. 275 pp. $5.

This second work completes the late Miss Goldstine's compilation of selections from the literature of medical social work, which began with her "Readings in the Theory and Practice of Medical Social Work" (1954). The present volume is divided into 2 parts, 1 noting the contributions of medical social work to medical care, the other the participation of medical social workers in the professional education of social workers and others.

FLUORIDATION AS A PUBLIC HEALTH MEASURE. Edited by James H. Shaw. American Association for the Advancement of Science, Washington. 1954. 232 pp. $4.50.

Addressed to the public-health worker, the civic official, the waterworks engineer, and the interested layman, this volume, consisting of about a dozen papers by scientists in different fields, offers what the preface calls "a reasonably complete evaluation of the present knowledge of the relation of fluoride ingestion to human health."

THE GROWING FAMILY; a guide for parents. Edited by Maxwell S. Stewart. Foreword by Sidonie Matsner Gruenberg. Harper & Bros., New York. 1955. 256 pp. $3.50.

This book is addressed primarily to parents, teachers, and others who deal directly with children. It is composed of individual pamphlets originally published by the Public Affairs Committee.

HOW TO WORK WITH YOUR BOARD AND COMMITTEES. Louis H. Blumenthal. Association Press, New York. 1954. 64 pp. $1.

Social workers and board members need each other's support, says the author of this book—a support that is more likely to be forthcoming when each is sensitized to the attitudes, the thinking, and the working methods of the other. The book traces the evolution of the board-staff partnership, describes how it operates, and shows that the basic factor is an understanding of board and staff members as individuals and as human beings.

FEEDING YOUR CHILD. Samuel M. Wishik, M. D. Forward by Leona Baumgartner, M. D. Doubleday & Co., Garden City, N. Y. 1955. 223 pp. $3.50.

Mentioning the common things that happen in connection with feeding, and suggesting what *might be done*, about them, the author maintains throughout this book that "the right method is the one that is right for you." For example, his first chapter, "Shall I Nurse My Baby?" addressed to the pregnant woman, makes the point that "the final decision is yours." Nearly three-fourths of the text applies to infants.

CEREBRAL PALSY; its individual and community problems. Edited by William B. Cruickshank, Ph.D., and George M. Raus, M.D. Syracuse University Press, Syracuse, N. Y. 1955. 560 pp. $7.50.

In this collection of papers by several authors, the editors have brought together medical, psychological, therapeutic, social-work, and rehabilitation points of view on the cerebral-palsy

problem. Part A, Diagnosis and Assessment, takes up the magnitude of the problem, its medical aspects, evaluation of cerebral-palsied children's intelligence, their personality characteristics, and their hearing and speech problems. Part B, Planning for Life Adjustment, discusses physical and occupational therapy, educational planning, mental retardation, parent education and counseling, vocational guidance and placement, social casework, rehabilitation, and total community planning for the cerebral palsied.

CHILD DEVELOPMENT. Millie Almy. Henry Holt & Co., New York. 1955. 490 pp. $6.

Using 6 life stories derived from longitudinal studies conducted by the Harvard School of Public Health as a framework, the author first depicts the young people at the age of 18. She then goes back to the time of their birth, describing the families into which these boys and girls were born and proceeding with illustrations of successive stages of their development. She suggests that with more research on development in the years beyond childhood and adolescence "child development may be more clearly seen in its proper perspective as one phase of human development."

QUESTIONS PARENTS ASK. James Lee Ellenwood. E. P. Dutton & Co., New York. 1955. 155 pp. $2.50.

After discussing the questions of hundreds of parents the author brings up one that he thinks parents should ask themselves: "What do we hope for our youngsters, anyway?" He lists possible objectives as: sound physical health, mental alertness, conscientiousness, and social acceptability, and calls the quality of conscientiousness "perhaps the most desirable of all traits, setting our standards and determining the pattern of our living."

COUNSELING WITH YOUNG PEOPLE. C. Eugene Morris. Association Press, New York. 1954. 144 pp. $3.

Designed to help volunteer leaders of youth groups to advise members who turn to them for help, this book offers suggestions to anyone who serves as such a leader in a social-work, recreation, religious, or youth-serving organization. It discriminates between areas in which such leaders can be helpful and those which call for referral to professional services.

THE STORY OF NURSING. Bertha S. Dodge. Little, Brown & Co. New York. 1954. 237 pp. $3.

Addressed to girls thinking of entering nursing school, this book tells the history of the nursing profession.

THE ART OF CHILD PLACEMENT. Jean Charnley. Introduction by Dorothy Hutchinson. University of Minnesota Press, Minneapolis. 1955. 265 pp. $4.50.

This book urges that foster placement be considered not merely a resource to be used only when all else has failed, but rather as a tool "to prevent total destruction of what is healthy and sound in a shaky family situation."

It discusses placement of very young children; establishment of relationships between the social worker and the older child who is not yet adolescent; values of the foster home and of the institution; and casework with "own" parents, with foster families, and with adolescents.

YOU AND YOUR RETARDED CHILD; a manual for parents of retarded children. Samuel A. Kirk, Ph.D.; Merle B. Karnes, Ed. D.; Winifred D. Kirk, M. S. Macmillan Co., New York. 1955. 184 pp. $4.

The authors address this book to parents of retarded children; to doctors, psychologists, social workers, and educators, who are frequently called on to advise these parents; and to relatives and friends of families with retarded children. Chapters include, among other subjects, a discussion of normal stages of development as a measuring rod for retardation, and ways of helping retarded children to become more independent, to play, to learn to talk and to control their behavior.

TWO LEGS TO STAND ON. John D. McKee. Appleton-Century-Crofts, Inc., New York. 1955. 180 pp. $2.75.

Now over 30 years old, the author tells how he has conquered a large part of the handicap of cerebral palsy. He completed 4 years of college at a distance from his home. He earns his living. He can swim and drive a car. His parents, especially his mother, are credited with teaching him—urging him—to learn to be independent.

HELPING YOUR CHILD'S EMOTIONAL GROWTH. Anna W. M. Wolf and Suzanne Szasz. Introduction by Milton J. E. Senn, M. D. Doubleday & Co., Garden City, N. Y. 1954. 305 pp. $5.

More space is given in this book to pictures than to words, as the author and the photographer present common life situations involving parents and children. Much of the content is focused on "certain important moments in a child's life that are harder for him than others, and times when he may need your special help and understanding to enable him to go forward and take the next step in healthy, happy development."

THE ONLY CHILD; a guide for parents and only children of all ages. Norma E. Cutts and Nicholas Moseley. G. P. Putnam's Sons, New York. 1954. 245 pp. $3.50.

After studying the histories of more than 250 persons, each of whom was an only child, the authors of this book offer advice to parents on helping an only child to develop a healthy personality. They say: "The problems which an only child faces are essentially those faced by all human beings. Onliness is at most a complicating factor."

PERINATAL MORTALITY IN NEW YORK CITY; responsible factors. Analyzed and reported by Schuyler G. Kohl, M. S., M. D., Dr. P. H. Published for the Commonwealth Fund by Harvard University Press, Cambridge, Mass. 1955. 122 pp. $2.50.

The second and final phase of an intensive study of infant mortality in New York City is reported in this volume, which presents an analysis of the clinical records of 955 babies and their mothers. All the babies had been stillborn or had died at birth or within a month afterward. In the opinion of a subcommittee of the New York Academy of Medicine's committee on public-health relations, which studied the cases, 35 percent of the deaths were preventable.

FILMS ON CHILD LIFE

Films listed here have been reviewed by staff members of the Children's Bureau. The listing does not constitute endorsement of a film, but indicates that its contents have merit. Charges for rental or purchase, not given because they change, may be obtained from distributors.

A LONG TIME TO GROW, Part 2. (Studies in Normal Personality Development Series.) 35 minutes, sound, black and white, purchase or rent.

Shows development of children 4 and 5 years, old, with flashbacks to earlier ages to suggest the gradual nature of changes in the child as he grows older. (Part 1, noted in CHILDREN, September–October 1954, was concerned with children from 2 to 3.)

Audience: Students preparing for professional fields concerned with children; parents, general public.

Produced by: Department of Child Study, Vassar College.

Distributed by: New York University Library, 26 University Place, New York 3, N. Y.

WHAT ABOUT JUVENILE DELINQUENCY? 11 minutes, sound, black and white, purchase.

Points to the complexity of the juvenile-delinquency problem in a high-school group.

Audience: Community groups.

Produced by: Young America Films, Inc., 18 East 41 Street, New York 17, N. Y.

Distributed by: Same.

GETTING ALONG WITH PARENTS. 14 minutes, sound, black and white or color, purchase.

Presents both sides of an apparent impasse between a group of teen-agers and their parents over a class dance. The parents of one of the young people work out a plan successfully with the other parents and the teen-agers. Suggests the value of family discussion of mutual problems.

Audience: Parents; teen-agers.

Produced by: Encyclopaedia Britannica Films, Wilmette, Ill.

JOHNNY'S NEW WORLD. 16 minutes, sound, color, purchase or rent.

Offers an example of a boy whose failing eyesight is interfering with his school success. When his teacher discovers his trouble, she joins with the school nurse to refer him to an eye specialist. The film also takes up the problem of crossed eyes.

Audience: Parents.

Produced by: National Society for the Prevention of Blindness, 1790 Broadway, New York 19, N. Y.

Distributed by: Same.

CHILDREN WITH NEPHROSIS. 12 minutes, sound, color, loan.

Indicates various stages of treatment for children with the serious kidney disease called nephrosis.

Audience: Students preparing for the medical and related professions.

Produced by: Campus Film Production.

Distributed by: National Nephrosis Foundation, 143 East 35th Street, New York 16, N. Y.; and Pfizer Laboratories, Film Library, 630 Flushing Avenue, Brooklyn 6, N. Y.

A companion film, "Nephrosis in Children," may be borrowed by physicians.

RETURN TO LIFE. 23 minutes, sound, color, purchase or loan.

Shows how handicapped children are served under a State crippled children's program, especially those with a congenital heart condition requiring surgery.

Audience: Parents of handicapped children.

Produced by: University of Illinois, Division of Services for Crippled Children, 1105 South Sixth Street, Springfield, Ill.

Distributed by: Same.

MOTHERS OF ACARI. 10 minutes, sound, black and white, loan.

Shows how a maternal- and child-health clinic was established in a small town in the interior of Brazil. The project was started through local efforts. Then the Brazilian Government provided a building, and UNICEF equipped it and trained a local young woman as a midwife.

Audience: Professional and lay groups.

Produced by: United Nations Department of Public Information.

Distributed by: Same.

THREE TO MAKE READY. 45 minutes, sound, black and white or color, purchase or rent.

Illustrates the efforts of specialized workers to rehabilitate patients: a 5-year-old boy with paralyzed legs; a 20-year-old cerebral-palsied girl, severely handicapped; and a 48-year-old widower, crippled by an industrial accident, who is the father of two boys.

Audience: General public, especially community groups contemplating the possibility of setting up a rehabilitation center.

Produced by: Institute for the Crippled and Disabled, 400 First Avenue, New York 10, N. Y.

Distributed by: Same.

YOUR CHILDREN WALKING. 20 minutes, sound, black and white, purchase.

Shows X-ray views of children's feet in motion. Makes clear the importance of good habits of walking, of proper footwear, and of general good care of the feet.

Audience: Parents and professional workers concerned with the care of young children.

Produced by: British Information Service.

Distributed by: McGraw-Hill Book Co., Text Film Department, 350 West 42d Street, New York 36, N. Y.

FROM SOCIABLE SIX TO NOISY NINE. 22 minutes, sound, black and white or color, purchase.

Illustrates daily life in a family consisting of father, mother, 6-year-old daughter, and 8- and 9-year-old sons. A narrator comments. This film is one of a series, "Ages and Stages."

Audience: Parents and students preparing for professions in which understanding of child behavior is needed.

Produced by: National Film Board of Canada.

Distributed by: McGraw-Hill Book Co., Text Film Department, 330 West 42d Street, New York 36, N. Y.

PROJECTS AND PROGRESS

Conference on Health and Delinquency

With the holding of a 3-day conference on Health Services and Juvenile Delinquency, in Washington May 19–21, the activities of the Children's Bureau's Special Project on Juvenile Delinquency came to an end. Set up 3 years ago and supported by private funds, the project helped States and local communities in efforts to prevent and treat juvenile delinquency. Its functions will be carried on by the Bureau's new Division on Juvenile Delinquency Services.

The health conference, last of the project's series of conferences on various phases of delinquency prevention, was attended by 77 doctors, nurses, medical social workers, and representatives of other professions in health services from 25 States. Called together to consider the role in combating dissocial behavior of "all persons who offer health service whether by private or public means," the conferees focused on the mental-health contribution of health personnel who had not had specialized training in this field.

After an opening session the conferees divided into four work groups to consider this contribution in relation to: (A) maternal and infant care; (B) children from 1 to 5 years old; (C) those from 5 to 12; (D) those 12 and over.

The first two groups pointed out that health personnel have a special opportunity to make a preventive contribution because of their close association with mothers and children at the time the mother's attitude toward the child is first forming, and in the early years of the child's life when the basic elements of his personality are being established. They pointed out that health personnel in prenatal, maternity, and well-child services and obstetricians and pediatricians in private practice especially are in strategic positions to foster the development of good parent-child relations.

Some of the practical steps suggested toward this end were: the provision of basic knowledge about personality development to all health workers so that they might help parents to understand their children and themselves in relation to their children and to learn to cope constructively with behavior problems; the participation by health personnel in efforts to strengthen and extend existing services and to create a health-inducing community environment; cooperation by health personnel with social-work agencies in serving unmarried mothers and their babies so that young children will not be deprived of the care of a mother or mother substitute.

Group C pointed up the responsibility of health personnel to be alert to early signs of maladjustment in children and of taking appropriate action. This, the conferees recognized, might involve instituting treatment, obtaining assistance from other health personnel, or making a referral to another type of service.

Group D concerned itself especially with the aggressive teen-ager or preteen-ager and of ways health personnel might work with him. The conferees suggested that health workers must join other agencies in reaching out to provide needed services to youngsters resistant to service. They especially underscored the responsibility of health personnel for aiding in the treatment of the adjudicated delinquent through cooperation with police, juvenile court, detention center, and training schools.

All the groups recognized that those services which are most effective in prevention are general in nature and not focused solely on the prevention of dissocial behavior—that it is impossible, at our present state of knowledge, to predict definitely the type of personal maladjustment that will result from maternal deprivation, poor parent-child relationships, environmental factors, or other personality-distorting conditions.

A full report of the conference, with the discussions reorganized under topical headings, will soon be available.

—Bertram M. Beck

Unmarried Mothers

Today as a rule the unmarried mother is willing and anxious to make careful plans for her child, and this is one of the most heartening developments in this field, according to a 51-page report published recently by a committee of the National Conference of Catholic Charities. The report carries information from 43 Catholic maternity homes in 22 States and the District of Columbia. These homes have facilities for more than a thousand mothers, and, in the 30 with nurseries, for nearly two thousand babies.

Noting that casework is the cornerstone of the program, the committee reports that all the 43 homes make some provision for this service before the mother enters the home and during her stay, and all but 11 provide it afterward. Nearly all the homes provide prenatal and postnatal care and medical emergency care; the rest use local hospitals for these purposes. Only 10 refer the mothers to hospitals for delivery. More than half the homes have salaried pediatricians on the staff or on call; somewhat less than half have pediatricians who donate their services. Nearly all the homes have recreational activities, but only one has a groupwork program as such.

The report notes as a good development the establishment of group homes, housing only six girls, with a minimum of rules, where freedom and responsibility are encouraged.

The unmarried mother's need of understanding, affection, and acceptance is stressed throughout the report. Especially it urges the importance of not taking a punitive attitude toward her.

Copies are available at $1.25 from the Conference, 1346 Connecticut Avenue, NW., Washington 6, D. C.

Juvenile Delinquency

New York City's Community Service Society recently recommended to a State commission that a citywide youth court be created to take the place of the many courts and court divisions now handling youth cases.

The proposed court would be part of a comprehensive family court, previously proposed by the society, to have jurisdiction over all court cases involving problems concerning children, young people, and families.

The society's plan would make noncriminal proceedings mandatory for all defendants over 16 but not yet 21, except those charged with homicide or those 19 or over who have committed certain other felonies. Under noncriminal proceedings the defendant is

not charged with a crime, but with being a "youthful offender," and is detained separately from older defendants. If guilty he is not given a criminal record. The courts now may hold such proceedings at their discretion, but only for youths under 19.

The society proposed that if a minor pleads not guilty to being a youthful offender he will have the right to trial by jury unless he specifically waives it. It also proposed that: before ordering a plan for treatment the court have a study made of the youth's "nature and circumstances"; those responsible for the study submit a recommendation for disposition of the case; reasons be placed on record when other than the recommended disposition is made.

Copies of the 154-page report, "Justice for Youth; the courts for wayward youth in New York City," may be had from the Society, 195 East 22d Street, New York 10, N. Y. Price $1.

. . .

Thirty proposals for research resulted from a conference on psychiatric research in regard to juvenile delinquency held in Princeton, N. J., last spring, under the sponsorship of the Welfare and Health Council of New York City with support from the Edward L. Bernays Foundation, Inc.

The suggested studies fall into six general areas: personality traits and characteristics including possible constitutional factors which predominate among delinquents; group dynamics and the causes of group conflicts; environmental studies conducted by interdisciplinary teams of psychiatrists, sociologists, and statisticians; social pathology as a causal factor in disorder among young people; interaction between personality, environment, and culture and its effect in producing delinquency; normal development and maturation as a norm for recognizing deviation.

Such studies, the conferees suggested, should be undertaken in "the laboratory of life"—the home and family, the clinic and hospital, the school and playground, the neighborhood and larger community, and the social agency. Recognizing that solution of the serious problem of retention and recruitment of personnel is vital to any research or operational program, they also recommended research into the characteristics of the effective "therapeutic" personality.

The conference was first in a series on various aspects of research in delinquency planned by the Council. The 27 persons attending were nationally known specialists in child development, psychiatry, research, welfare, and health.

A full report of the conference is available from the Welfare and Health Council, 44 East 23d Street, New York.

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Late in July the Senate, by resolution authorized its Judiciary Committee's Subcommittee To Investigate Juvenile Delinquency to continue to January 31, 1956. Given an additional $125,000 by Congress in March 1955 plus $29,000 in July to pursue studies of juvenile delinquency, the subcommittee is conducting hearings on various aspects of the problem, such as how lack of suitable employment opportunities for young people contributes to delinquency and what effect pornographic materials have on youth behavior. It is also concerned over the black market in babies. (See column 3.)

Trachoma

In an effort to discover a safe vaccine that will prevent trachoma, the Harvard School of Public Health and the Arabian American Oil Company recently began a 5-year $500,000 research program. Previous efforts to control this widespread and often blinding eye disease have been focused mainly on finding a cure.

Though the new research program will be directed primarily toward the development of a vaccine, it will also involve other aspects of trachoma control—medical treatment; the elimination of possible transmission agents, such as insects and insanitary conditions; and efforts to build up resistance to infection in exposed persons. It will also be concerned with the control of other types of eye infection.

Migrants

New York State's new regulations to improve living conditions at farm-labor camps specify minimum standards that must be met before any person may operate such a camp. Each camp operator must obtain a permit each year from the full-time local health officer, who is responsible for ascertaining that living conditions at the camp meet the detailed standards set by the regulations. Previously standards for such camps were covered only in general terms in the State sanitary code.

. . .

Even more local than migrant children under 16 are employed in agriculture during school hours according to the U. S. Department of Labor. Members of the Department's staff investigating such employment, which violates child-labor provisions of the Fair Labor Standards Act, found that in 3 successive fiscal years—1953, 1954, and the first 6 months of 1955—local children represented 57 percent, 60 percent, and 56 percent, respectively, of the total.

Adoption

A number of adoption agencies in the San Francisco Bay area, public and private, along with two organizations specifically concerned with minority-group problems, are beginning a joint 3-year project to find adoptive homes for Negro and Latin-American children. The committee responsible for formulating policy is known as MARCH which stands for Minority Adoption Recruitment Committee for Homes. The Columbia Foundation has granted funds to support the first year's activities.

The program is part of a widespread effort to recruit foster-family homes, including adoptive homes, which the National Urban League is developing in various cities.

. . .

Testimony on a black market in babies occupied 2 of the 3 days of hearings held in Chicago in mid-July by the Subcommittee to Investigate Juvenile Delinquency of the Senate Judiciary Committee. Witnesses told of activities involving the sale of babies that had occurred in Chicago, in Oklahoma, and Texas, and in a New York-focused traffic from Montreal, Florida, and Massachusetts.

Senator Estes Kefauver (Tenn.) served as chairman of the hearings, which were attended also by Senators Edward J. Thye (Minn.) and William Langer (N. Dak.).

Two representatives of the Children's Bureau, Mildred Arnold, director of the Division of Social Services, and Margaret Thornhill, special consultant, were called on to comment on the kinds of services neded for sound adoption placement and conditions that force unmarried mothers to turn to independent

arrangements. Sound placement, they emphasized, involves: getting to the unmarried mother as early as possible; providing her with the kind of social service that can help her arrive at an early and firm decision on whether or not to give up her child; the use of social service in the selection and supervision of adoptive homes; the provision of good medical care for mother and child; good legal machinery for the relinquishment of the child by its natural mother.

Community services and facilities need to be greatly increased and the mother's confidence respected if placements through individuals are to be avoided, the Children's Bureau representatives said.

Research in Prostheses

A university research project on prosthetic appliances for adults who have lost an arm or a hand was recently broadened to include children under the State crippled children's program. California's State department of public health has joined the University of California at Los Angeles in this work to determine (1) what kinds of prosthetic appliances are best suited for young children; (2) how early children with congenital amputations can be successfully fitted with such appliances; (3) what kinds of training will enable the children to make the best use of them.

Each child accepted is studied at the Marion Davies Pediatric Center by a team consisting of an orthopedic surgeon, a pediatrician, a psychologist, a social worker, an occupational therapist, and a prosthetist, all on the staff of the university's departments of medicine and engineering. On the basis of this study, children are referred to the university's engineering department for the prescription and fitting of a suitable prosthetic appliance. The child and his parent live near the university for 2 to 4 weeks so that they can be trained in the use of the device. Later they return for followup visits at intervals of 3 to 6 months, as long as these are necessary.

Medical Care

Nearly a million and a half children now have some medical care available to them through the aid to dependent children program under the Social Security Act, according to the office of the Commissioner of Social Security, Department of Health, Education, and Welfare. All but 9 States provide financially for some medical care for children through this program. In some States the care provided is comprehensive; in others it is relatively slight.

Under the act, the State public-welfare agency may use either or both of two methods of paying for medical care to families receiving funds through ADC or any of the other federally aided assistance programs. By one method, the agency includes amount to pay for such care in the money payments to the families. By the other it makes direct "vendor payments" to doctors, hospitals, and others providing the care.

In the 22 States reporting on vendor payments in ADC in January 1955, the average monthly payment per family ranged from $17 to less than 1 cent.

During the fiscal year 1954 vendor payments for medical care for families receiving aid to dependent children amounted to $15,600,000 of State and Federal ADC funds, plus $1,600,000 of general-assistance funds from State and local sources.

Additional amounts for medical care, provided as part of the money payments to families, raised the total medical-care expenditures in ADC to a probable $26,000,000, an average of $3.70 per family per month, and 4.6 percent of the total assistance expenditures under the ADC program.

Eye Clinics

The New York City Department of Health recently made an analysis of the costs and operations of the 23 eye clinics operated as part of its services to crippled children. It found that the 30,794 individual children seen in the clinic during 1954 cost the department $3.22 per child per year for clinic personnel and $1.71 per clinic visit. An average of 11 children were examined in each 3-hour ophthalmological session.

Of the 29,429 ophthalmological diagnoses made, refractive error occurred most frequently, accounting for 88.4 percent. Strabismus, or squint, accounted for 8.3 percent; "diseases and defects," including infections, for 2.5 percent; and developmental anomalies for 0.8 percent. Sixty percent of the children with refractive errors were suffering from myopia, or nearsightedness; 40 percent from hyperopia, or farsightedness.

Ninety percent of the children were referred to the clinics as a result of school screening tests in which they failed to read 20/40 on a Snellen chart. Only 1.6 percent were preschool children referred by child-health stations or day-care centers, a fact which the department attributes to the lack of a preschool vision program in the community.

One serious problem revealed in the analysis was the high rate of broken appointments. While 58,000 visits were made to the clinic, 38,283 others had been scheduled but unkept.

Child Welfare

A followup study to evaluate the work of a children's reception center in Kent County, England has shown "fairly conspicuous improvement" among more than half of 200 children for whom the center's staff had recommended various types of care to the county welfare department.

Material for the study was gathered through personal study of 100 children by a psychiatrist and a psychiatric social worker and through inquiries by correspondence concerning 140. The former involved home visits and included interviews with the children and with mothers, foster mothers, teachers, and welfare workers.

While not all the children showed improvement, the proportion in good psychological and social condition had more than doubled. Sixty-three percent had improved; 29 percent had not changed; 8 percent were worse.

Study centers for children are now required by act of Parliament in all counties. The one in Kent County, however, financed by the Nuffield Foundation, was established before the act was passed.

The story will not be complete until the children have grown up and have become citizens and parents, says Hilda Lewis, the psychiatrist, in her report, "Deprived Children; the Mersham experiment, a social and clinical study," published by Oxford University Press, New York.

. . .

North Carolina's county departments of public welfare provided services other than financial to nearly 50,000 families during the fiscal year ended

June 30, 1954. The largest proportion of the services, 36 percent, were direct services to individual children. Other nonfinancial child-welfare services were provided: to families adopting children (5 percent); in cases of nonsupport of children (4 percent); and for finding, licensing, and supervising foster homes (3 percent).

Sixty-two percent of the families receiving such services were white, 37 percent, Negro, and less than 1 percent, Indian.

Facts and Figures

Although the urban and rural populations of the United States are growing at approximately the same rate, the number of children under 15 is increasing faster in urban than in rural areas, according to the Bureau of the Census, Department of Commerce. Between April 1950 and April 1954 the rural population as a whole increased by 6.3 percent; the urban by 5.6 percent. During the same period the number of children under 15 in urban areas rose by 17.9 percent (from 23,400,000 to 27,600,000); and the number in rural areas by 12 percent (from 17,100,000 to 19,200,000). The gain of 4,200,000 in the child population of urban areas accounted for three-fourths of their total increase in population. The 2,100,000 gain among rural children accounted for three-fifths of the total rural-population increase.

. . .

School enrollment in rural areas has increased since the child-labor provisions of the Fair Labor Standards Act were amended to prohibit employment of children under 15 in agriculture during school hours. Between 1951, the year after the amendment became effective, and 1954, enrollment of rural children 10 through 15 years rose from 94 percent to 97 percent. Enrollment of urban children in the same age group remained stationary at 99 percent.

. . .

Of the estimated 4,067,000 births in 1954 in the United States, about 300,000 (7.6 percent) were premature. No information is yet available on the deaths of premature infants in 1954; but in 1952 deaths of such infants represented about 57.5 percent of all deaths in the first 4 weeks of life and 41 percent of all deaths in the first year.

Infant deaths were 2,000 fewer in 1954 than in 1953, though 112,000 more babies were born in 1954. The infant mortality rate for each month of 1954 was lower than the rate for that month in any earlier year. For the entire year, there were 26.8 deaths of infants under 1 year for every 1,000 live births, the lowest national annual rate so far recorded. Data for individual States are not yet available.

. . .

Divorces in the United States in 1953 amounted to 390,000. The figure is far below the peak reached in 1946, when 613,000 divorces were granted.

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National per capita income continues to increase. For the United States as a whole, the per capita annual income was $1,709 in 1953, an increase of 4 percent over the figure for 1952. In 1953, for the richest State, Delaware, it was $2,304; for the poorest, Mississippi, it was $834.

. . .

Of every 7 children under 18 years in the United States in 1953, 1 was living with only one parent or with neither parent. About 4,700,000 children were living with one parent, usually the mother, and 2,400,000 with neither parent. Of the latter group 1,700,000 were with relatives, and 700,000 were in foster-family homes or institutions or were living alone. The total number living with only one parent or neither was 7,000,000.

. . .

Births out of wedlock totaled 150,300 in 1952, the latest year for which figures are available. This was 68 percent greater than the number in 1940, and probably represents an all-time peak. In 12 years the rate of such births per 1,000 unmarried females more than doubled, going from 7.1 in 1940 to 15.2 in 1952. Except for 1948, births out of wedlock have increased each year since 1940.

. . .

Of the 1,500 people who die each year through accidental poisoning, more than 20 percent are children between the ages of 1 and 4 years of age.

Here and There

A 3-year study to learn how orthopedically handicapped children and youth can participate in group-work and camping activities is beginning under the supervision of the Welfare and Health Council of New York City. The project, which will be largely supported by a grant from the Association for the Aid of Crippled Children, will involve a total of about 180 children and will have a distinct research aspect.

. . .

The Women's Adoption International Fund, known as WAIF, originally organized by the Hollywood movie colony to bring homeless children from abroad to this country for adoption, has become a fund-raising branch of International Social Service, Inc. Its first drive for funds got underway last summer.

. . .

A committee to examine all Travelers Aid Services to Children was formed recently by the National Travelers Aid Association. Establishment of the committee is an outgrowth of the work of the Association's committee on children traveling alone.

. . .

Baltimore's City Health Department recently issued a "Handbook of Vital Records Information for Attorneys and Welfare Workers." It explains practices of the department's vital-records office, with special attention to alteration of birth certificates in cases of adoption, legitimation, adjudication of paternity, and legal change of name.

. . .

To finance a 3-year survey of the value and effectiveness of school health services in the city of New York, the Public Health Service, United States Department of Health, Education, and Welfare, has granted $159,940 to the Welfare and Health Council of New York City.

. . .

Mental Health Materials Center, Inc., by arrangement with the Canadian Government, recently brought out a United States edition of seven leaflets on child training produced by Canada's Department of Health and Welfare, Ottawa. The titles are: Lying and Stealing; Discipline; Obedience; Sex; Temper; Destructiveness; and Preparing Your Child for School. Prices and other information from the Center, 1790 Broadway, New York 19, N. Y.

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Frontispiece, Farm Security Administration. Page 165, Western Reserve University. Pages 170, 171, and 180, Philip Bonn.

READERS' EXCHANGE

CIANCI: ***Residences for the retarded***

I was delighted with Vincentz Cianci's "Home Training for the Mentally Retarded Child," (CHILDREN, May–June 1955), particularly with her emphasis on the need for residential care. As a founder of and parent-leader and writer-volunteer for the National Association for Retarded Children I have become concerned about the place of the institution in a total program for the retarded. In the effort to press for intermediate facilities between total home care and total institutional care, the inclusion of residence centers in the total community planning picture has sometimes been lost.

Placement outside the home is often essential for many reasons—the severity of the child's handicap; death or poor physical or mental health among other members of the family; lack of community facilities in sparsely settled areas; and lack of community acceptance in areas not so sparsely settled.

We must strive to make our residence centers more homelike and constructive (through training programs) and reasonably accessible so that parents can keep the institutionalized child within the sheltering arms of his own family.

Letha L. Patterson
Board member, National Association for Retarded Children, Stillwater, Minn.

ROBINSON: ***Data-sharing needed***

In referring to the current research by Community Research Associates Marion Robinson states: ". . . the potential gains which may accrue from the experiment . . . may be enormous but are as yet unpredictable." ("A Team Approach in Preventing Maladjustment," CHILDREN, March-April 1955.) Indeed, the contribution may be enormous, but it will not and cannot reach its potential if the publication pattern of Community Research Associates continues as at present, with seeming oblivion of the absolute necessity to reveal *theoretical structure, hypotheses, methods, and findings* as well as conclusions and recommendations.

Judged in terms of its performance to date, Community Research Associates has failed to recognize or make evident its recognition of some fundamental prerequisites in the development of knowledge.

Scientific knowledge and the use of such knowledge must be dependent upon the accretion process. Without the possibility of building upon the accomplishments and failures of the past, science and professional practice remain limited to the capability of the single individual or single organization.

In the development of a scientific base for social-work practice the traditional procedures of accretion of knowledge have generally been followed. This has included the publication of research procedures and findings, practitioners' insights and observations, theoretical and philosophical formulations. As a field we have, at times, however, failed to remember that the methods we follow, the tools we use in obtaining information are all important contributions in themselves and always an inseparable part of the findings and conclusions we report. When reported they become not only possible tools for further research but also indispensable clues to the merit of data and conclusions they have served to elicit.

Community Research Associates, the most affluent single social-work research organization in this country, restricts the release of basic data in such a manner that it is neither prudent to use its findings and conclusions nor possible to build upon its methodological advances. Clearly, the St. Paul study, the current studies in Hagerstown, Md., Winona, Minn., and San Mateo, Calif., the project on classification of family disorders, all have great *potential* usefulness to the field of social work. However, if the pattern of partial and inadequate release of research material established with the publication of *Community Planning for Human Services*, (Bradley Buell and Associates, Columbia University Press, New York 1952) is continued, the actual usefulness of the published material will remain limited.

There are indications that it is destined to continue. In discussing the research design and methodology of a project on classification of family disorders, at a meeting of the New York Social Work Research Group last winter, a staff member of Community Research Associates indicated that certain data on methodology, findings, and conclusions, already in printed form, were available neither to the social-work profession as a whole nor to the public because "they might be misinterpreted."

It is hoped that Community Research Associates will continue to thrive and to contribute to the growing supply of social work knowledge. It is also hoped that this organization, along with all of us in social-work research and social-welfare planning, will learn the value and absolute necessity of improved communication in research ideas, practices, and findings, in order to permit the critical evaluation and possible extension and enhancement by the field as a whole of the contributions of every individual and organization.

Martin Wolins
Associate Director, Institutional Cost Study, Child Welfare League of America

[Editor's note: A letter from Bradley Buell, director of Community Research Associates, will appear in the November-December issue of CHILDREN in response to Mr. Wolins.]

FOSTER: ***Responsibility for prevention***

It is refreshing to read in Katharine Foster's article ("Stabilizing Influences in Helping Handicapped Children," by Katharine L. Foster, CHILDREN, March-April 1955), of the philosophy of the staff members of the Massachusetts Hospital School for Crippled Children to "never give up, while a child is under care, the efforts to seek out and build on the stabilizing factors which can sustain his future." Too often social workers, as well as other professional personnel having responsibility for the rehabilitation of an individual child, concern themselves solely with the very personal relationship between one professional staff member and the child. Too often, also, we may ignore the many other forces within the child's own family group as well as within the wider environment of his total community which could be utilized as posi-

tive factors in the attainment of the goals of rehabilitation.

As Miss Foster points out there is also an imperative need for social workers and other personnel to accept their responsibility in the field of prevention. A supportive relationship to an individual at crisis periods in his life may produce lasting changes in that individual.

Margaret G. Holden
Supervisor, Medical Social Training Project, Division of Services for Crippled Children, University of Illinois

de ZAYAS: ***Nutrition education, an art***

The effects of coordination and cooperation rather than competition between existing agencies are well demonstrated in Dr. de Zayas' description of the Puerto Rican nutrition program ("Better Nutrition for Puerto Ricans," by Esther Seijo de Zayas, CHILDREN, March–April 1955.) One senses that the Nutrition Committee did not feel that *their* plans were the only, or even the best, solution to the pressing health problems that arise from any environment in which the available quantity and quality of food are inadequate to meet human needs.

The development of the Basic Four poster was a realistic acknowledgement of the foods available and preferred, and its basic philosophy is of help to workers in other countries as well as in Puerto Rico. . . .

The feeding programs described are so extensive as to give the Nutrition Committee a real means of evaluating their demonstration techniques. Nutritionists on the mainland remember sadly that during the depression, nutrition education tried to "run" but could not begin to "catch up" with the needs of those to whom surplus food was distributed. I recall finding a woman cooking a grapefruit and remarking that "it didn't get done!"

Disbursement of foods is an administrative technique; nutrition education is an art and a science that requires that we evaluate our efforts in the terms of the health of the people.

Only the years will prove the answer now sought by all workers who are attempting to develop nutrition programs which meet the total needs of the people they serve.

Adelia M. Beeuwkes
Associate Professor of Public Health Nutrition, School of Public Health, University of Michigan

A lesson for the mainland

Puerto Rico's nutrition program as described by Esther Seijo de Zayas might well be emulated by many a health department on the mainland, particularly in regard to the following features:

1. Basing the program on "real" needs as shown by dietary intake and health-status data, such as selected mortality and morbidity statistics.

In many health programs the latter data are ignored as an indication of nutritional needs simply because they do not show poor nutrition as the *sole* cause of death or illness.

(I would however, question the validity, as an indication of nutritional status, of a comparison of height-weight data for children in Puerto Rico with children on the mainland, unless the comparison is made between children with similar hereditary background.)

2. Planning the nutrition work as part of a total health program.

To facilitate such planning, nutrition personnel must be administratively so placed in a health department that their services can be made readily available to all other divisions or bureaus—an achievement made possible in Puerto Rico through creation of the Bureau of Nutrition and Dietetics.

3. The inclusion of many agencies and many disciplines in the program.

4. Positive recognition of the attitudes and cultural values of the population.

Ruth L. Huenemann
Associate Professor of Nutrition, School of Public Health, University of California, Berkeley

FOR YOUR NOTEBOOK

In 1954, for the third consecutive year, marriages dropped below 10 per thousand population. The rate for 1954 was 9.2, the lowest since 1933. Decline in marriages in recent years has generally been attributed, says the National Office of Vital Statistics, Department of Health, Education, and Welfare, to the low birth rates in the 1930's to high marriage rates in 1946–47, and to continued "borrowing" from future marriages through reduction in age at first marriage.

. . .

The proportion of married persons in the population is increasing, according to the Bureau of the Census, Department of Commerce. In 1954 about 69 percent of the adult population were married; in 1940 the percentage was 60. More married couples maintain their own households. The percentage increased from 91.3 in 1947 to 96.1 in 1954.

. . .

Registered live births in the United States, it is estimated, reached an all-time high of 4,021,000 in 1954. This is 2.9 percent more than the number in 1953. The year 1954 becomes the fourth successive record-breaking year. The birth rate per 1,000 population was 25.0 in 1954; it was 24.7 in 1953.

. . .

Elementary school enrollment has increased about 19 percent, and kindergarten enrollment some 67 percent, since 1950, according to the Bureau of the Census, Department of Commerce. The number of children enrolling in elementary schools rose from 20,501,000 for the school year 1950–51 to 24,427,000 in 1954–55. Kindergarten enrollment went up from 902,000 to 1,509,000. Schools below the ninth grade have had to accommodate 4.5 million more children in the last 4 years.

High-school enrollment (grades 9 to 12) has grown 16 percent since 1950. From 6.7 million in 1950–51, the number of these pupils rose to 7.7 million for the 1954–55 school year.

. . .

Nearly 400,000 nurses—an increase of 16,000 since 1950—are now working in the United States, according to the Public Health Service, Department of Health, Education, and Welfare. National nursing organizations estimate that to provide the nurses needed by the country, 55,000 students should be entering nursing schools each year. In 1954 the schools admitted 44,930 students, the greatest number ever admitted in peacetime.

SOME U. S. GOVERNMENT PUBLICATIONS FOR PROFESSIONAL WORKERS

Publications for which prices are quoted are for sale by the Superintendent of Documents, United States Government Printing Office, Washington 25, D. C. Orders should be accompanied by cash, check, or money order. Twenty-five percent discount on quantities of 100 or more.

NUTRITION AND HEALTHY GROWTH. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Pub. 352. 35 pp. 20 cents.

Addressed to teachers, nurses, social workers, and others who work with parents, this pamphlet gives the essentials of good nutrition for the prenatal period, the infant, the preschool child, the school child, and the adolescent.

LEADERSHIP THROUGH CONSULTATION; how a State welfare department builds strength in agencies providing group care for children. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. 1955. 44 pp. Processed. Single copies from the Children's Bureau without charge.

"An analysis of philosophy, principles, and problems involved in State-agency consultation for institutions and day-care centers" as made in a 3-day conference of public-welfare consultants from Florida, Georgia, Mississippi, and Tennessee with staff members of the Children's Bureau.

THE 7th YEAR OF WORK, INTERDEPARTMENTAL COMMITTEE ON CHILDREN AND YOUTH. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. 1955. 20 pp. Processed. Single copies from the Children's Bureau without charge.

This annual report for the year ended June 30, 1955, describes the work of a committee that includes representatives of Federal agencies conducting programs that affect children's well-being. It summarizes the year's work, including study of agricultural migrants, juvenile delinquency, mental retardation, and transition from school to work.

ORGANIZATION AND STAFFING FOR FULL-TIME LOCAL HEALTH SERVICES. Clifford H. Greve and Josephine H. Campbell. Department of Health, Education, and Welfare, Public Health Service. PHS Pub. No. 441. 1955. 28 pp. Single copies from the Public Health Service without charge.

This report analyzes the coverage of areas in the United States by full-time local health organizations and the number and types of personnel engaged in local public-health programs as of December 31, 1953. It notes that minimum staffing deficiencies in the 1,389 local health organizations reporting approximated 1,700 physicians, 15,400 nurses, 3,000 sanitation workers, and 2,600 clerical workers.

PUBLICATIONS OF THE CHILDREN'S BUREAU, January 1955. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. 28 pp. Single copies available from the Bureau without charge.

Titles in this list include: (1) all publications of the Children's Bureau issued since 1950 that are available for general distribution; (2) earlier publications of the Bureau that are still available and of current value.

DIRECTORY OF STATE AND TERRITORIAL HEALTH AUTHORITIES, 1954. U. S. Department of Health, Education, and Welfare, Public Health Service, Bureau of State Services. PHS. Bull. 75. 1954. 73 pp. 30 cents.

Issued annually, this directory presents information on official State agencies administering health programs. Besides departments of health, the bulletin includes other State agencies such as those concerned with hospital planning and construction, mental hygiene, control of water pollution, and crippled children's services not in health departments.

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